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ABSTRACT

This document describes a comprehensive service delivery model for drug-exposed infants and their families, provides a compendium of programs and funding sources that target the needs of these families, and delineates areas in need of financial support and further exploration. Development of the model required a literature review, interviews, and networking to: (1) create a service delivery consensus document that provides an appropriate continuum-of-care of comprehensive medical, social, and support services for at-risk or drug-exposed infants and their families; (2) develop the compendium of funding sources and programs; and (3) develop policy recommendations and options for future directions. Descriptions of several federal government agencies and programs are provided, including the Substance Abuse and Mental Health Services Administration, the National Institute on Drug Abuse, and the Administration for Children and Families. Appendixes, comprising about half the report, discuss legal aspects of maternal drug abuse, treatment criteria, core services of residential rehabilitation programs, model projects, and program evaluation. A copy of the compendium of funding sources is also provided in an appendix; it lists funding programs of the General Services Administration; U.S. Departments of Agriculture, Education, Health and Human Services, Housing and Urban Development, and Justice; and private sources. (Contains approximately 126 references.) (JDD)

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AN ANALYSIS OF RESOURCES TO AID DRUG-EXPOSED INFANTS AND THEIR FAMILIES

The CENTER for HEALTH POLICY RESEARCH

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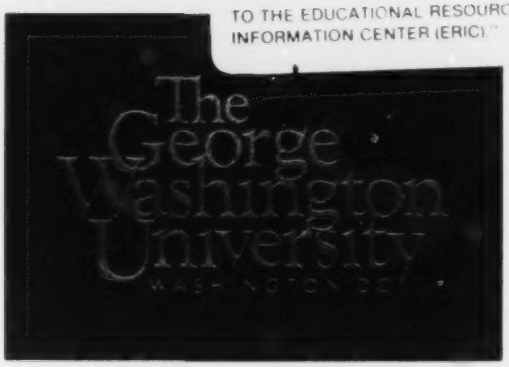

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AN ANALYSIS OF RESOURCES TO AID DRUG-EXPOSED INFANTS AND THEIR FAMILIES

Center for Health Policy Research
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KEY PROJECT PERSONNEL

Peter Budetti, M.D., J.D.
Principal Investigator

Dr. Budetti is the Director and Founder of the Center for Health Policy Research. He holds an endowed chair as the Harold and Jane Hirsh Professor of Health Care Law and Policy, serving as a full-time tenured regular faculty member in the Department of Health Services Management and Policy, School of Business and Public Management, with joint appointments in the National Law Center and the School of Medicine.

Between 1984 and 1990 he served as Counsel to the Subcommittee on Health and the Environment in the United States House of Representatives. He was the professional staff member with primary responsibilities for legislation and policy concerning health insurance reform, regulation of medical devices by the Food and Drug Administration, health professions education and health services research. From 1975 through 1984 he was with the Institute for Health Policy Studies, School of Medicine, University of California. Dr. Budetti is a pediatrician and lawyer. His medical degree is from Columbia University College of Physicians and Surgeons, and his law degree is from the School of Law, Boalt Hall, University of California, Berkeley.

Mary R. Haack, R.N., Ph.D.
Project Director

Dr. Haack is a Senior Research Scientist with dual appointments as Assistant Research Professor of Psychiatry and Behavioral Sciences and Adjunct Associate Professor of Health Care Sciences. Prior to her present position, she was a Visiting Scientist in the National Institute on Alcohol Abuse and Alcoholism and Associate Director for Research at the Center for Nursing, Northwestern University, Chicago. Dr. Haack has been on the faculty of the School of Nursing, University of Illinois at Chicago; the Marcella Niehoff School of Nursing, Loyola University of Chicago; and the School of Nursing, the University of Maryland. Her clinical background includes four years as nurse clinician in substance abuse treatment and six years as a psychotherapist in private practice. Since 1981, she has been Chairperson, Nursing Research and Practice Section, of the International Institute on the Prevention and Treatment of Alcoholism. Dr. Haack received her Ph.D. degree from the University of Illinois at Chicago and her undergraduate degree from Loyola University of Chicago.

Michele Solloway, Ph.D.
Senior Research Scientist

Prior to joining the Center, Dr. Solloway was a senior Research Associate with the Intergovernmental Health Policy Project where she was responsible for tracking state legislative and program activities concerning Medicaid, indigent care, access, employer-based health insurance, maternal and child health, and long-term care. Dr. Solloway received her doctoral degree in City & Regional Planning in May of 1991 from the University of California, Berkeley with field concentrations in health economics, labor policy and public finance.

Stephanie Spernak, J.D.
Senior Research Scientist

Ms. Spernak is a graduate of the Georgetown University Law Center, Washington, D.C. and a member of the District of Columbia Bar Association. She has specialized in civil litigation and administrative law. Ms. Spernak also holds a master's degree in journalism from the University of Maryland where she concentrated on medical and science writing. Her undergraduate degree is from the University of Pittsburgh.

Julie Darnell
Research Assistant

Prior to her involvement with the Center, Ms. Darnell worked for two years with the Subcommittee on Health, Committee on Ways and Means of the U.S. House of Representatives. As a Staff Assistant, she helped to formulate Medicare legislation, responded to inquires from the press and Congressional offices, tracked health legislation and Federal regulations, and coordinated briefings, mark-up sessions, and hearings. Ms. Darnell received her undergraduate degree from Saint Mary's College in Notre Dame, Indiana. She was also the recipient of the Lyndon Baines Johnson Fellow Award. She is currently a degree candidate in the Master of Health Services Management and Policy program at The George Washington University.

Julie Hudman, M.P.P.
Research Assistant

Ms. Hudman was previously an administrative liaison at the Washington Office of the UCLA Center for American Politics and Public Policy. Ms. Hudman received her undergraduate degree in political science from the University of Oklahoma and her graduate degree in public policy from Georgetown University.

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Judith Larsen, MA, JD, Special consultant on substance abuse to the American Bar Association Center on Children and the Law, Washington, D.C.

Jewell Oates, PhD, Executive Director, The Women's Treatment Center, Inc., Chicago, IL

Elizabeth R. Rahdert, PhD, Division of Clinical Research, National Institute on Drug Abuse

Paul R. Marques, PhD, Senior Scientist, and Doreen Gail Branch, Research Associate, Public Services Research, Landover, MD

Susan Galbraith, Legislative Representative, Legal Action Center, Washington, DC

Leslie Jordon, Director, Treatment Services, Division of Alcohol and Drug Abuse, Missouri Department of Mental Health, Jefferson City, MO

Janice McDonald, Director of Finance, Operation PAR, Inc., St. Petersburg, Florida

Dorynne Czechowicz, MD, Office of Policy and External Affairs, National Institute on Drug Abuse

Sue Ginsberg, Rachel Feldman, and Susan Buell, Lewin/VHI, The OSAP Resource Center for the Prevention of Perinatal Substance Abuse, Fairfax, Virginia

Dori Budetti, RN, BSN, Public Health Nurse, Department of Health Resource Services, Tampa, Florida

Maria Malilay, R.N., B.S.N., Neonatal Intensive Care, The George Washington University

Sara Rosenbaum, J.D., Center for Health Policy Research, The George Washington University

Lee Dixon, Bonnie Wilford, Jacqueline Morgan, Intergovernmental Health Policy Project, The George Washington University

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"The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little."

Franklin Delano Roosevelt

A NATION'S RESPONSE TO DRUG-EXPOSED INFANTS AND THEIR FAMILIES

The growing incidence of substance abuse has gained national prominence, as the problems which attend it continue to devastate all aspects of our nation's social fabric. Substance abusers and their victims have inundated our cities' hospitals (many of them already overburdened and financially distressed), drug treatment centers, welfare offices and prisons. Substance abuse problems of all types have become even more acute among women of child-bearing ages, particularly poor and minority women, and have been accompanied by an increasing number of infants born exposed to alcohol, nicotine and illegal drugs.

AIMS

The three objectives of this report are: (1) To describe a comprehensive service delivery model for drug exposed infants and their families; (2) To provide a compendium of programs and funding sources that target the needs of these families; and, (3) To delineate the areas in need of financial support and further exploration.

BACKGROUND

Drug Effects

Some of the immediate effects of substance abuse on expectant mothers and their infants are known. Drug exposed infants can suffer a wide array of temporary and enduring consequences which include prematurity, low birth weight, growth retardation, small head size, cerebral hemorrhage, hyperactivity, sleep disturbance, eating problems, learning difficulties and withdrawal symptoms. Effects of specific drugs have been identified largely through animal studies. In any given child, however, it is difficult to delineate a single drug effect since most addicts use several drugs. One drug is usually preferred, but other drugs are used to enhance, to substitute, or to counteract undesirable effects. Almost all addicts use legal drugs such as alcohol and nicotine in conjunction with illegal drugs.

One study funded by the National Institute of Drug Abuse (NIDA) examined 52 women who used cocaine throughout their pregnancy and found that one-third of the babies were born premature, 25 percent were of low birth weight and 15 percent died of sudden infant death syndrome (SIDS). Another study examined data on 400 infants and concluded that most mortality and morbidity among cocaine exposed babies is due to complications associated with premature birth and intrauterine growth retardation (ADAMHA News, 1989). While the problems associated with perinatal substance abuse and addiction have been most visible among users of crack-cocaine, perinatal exposure to alcohol and tobacco smoke can also have devastating effects. Alcoholic drinking can cause a cluster of birth outcomes, known as Fetal Alcohol Syndrome (FAS), including growth deficiencies, facial abnormalities and mental retardation.

Alcohol is the only drug known to have the direct effect of mental retardation and is the third leading cause of birth defects associated with mental retardation. Many more children are born with milder forms of FAS known as Fetal Alcohol Effect (FAE) that often go undetected (Seventh Special Report to the U.S. Congress on Alcohol and Health, 1990).

Developing children are also susceptible to the toxic effects of nicotine and secondary smoke within the environment. The fetal effects of maternal cigarette smoking, premature labor, low birth weight and SIDS, are very similar to cocaine (Volpe, 1992; Schoendorf & Kiely, 1992). A recent review of nine U.S. studies in The Lancet showed fathers who smoked cigarettes produced smaller babies and babies with higher rates of perinatal mortality. Babies of non-smoking mothers whose fathers smoked more than ten cigarettes a day had a greater frequency of severe malformations, independent of parental age and social class (Davis, 1991). Children have also developed neurologic symptoms such as seizures following passive inhalation of vaporized crack (Schwartz, 1989).

Prognosis of Drug-Exposed Infants

The presumption is that drug-exposed infants are more likely to have prolonged and chronic health problems and are perhaps more likely to require public assistance as a result of being permanently disabled in some way. This assumption, perpetuated by the media, has led the public to believe that these infants are "throwaway" kids. It is, however, largely unfounded. The long-term impacts of drug exposure on a child's physical, mental and social well-being are as yet unknown. Not all children are physically damaged as a result of maternal drug use. In fact, most effects of prenatal drug exposure are transient and responsive to treatment. Children

have a tremendous capacity to recuperate and accommodate if they grow up in an organized, nurturing environment (Volpe, 1992; Olegard, 1992; and Werner, 1989).

Some disabling effects of parental substance abuse are caused by teratogenic effects of a drug, but they can also occur as a consequence of broader social problems such as destitution, homelessness and hunger. Many addicted mothers live with poverty, violence, abuse, neglect, prostitution, mental illness, and psychological and physical abandonment. Physical maltreatment by chemically involved mothers and fathers also has detrimental effects. Response to any one prenatal or postnatal environmental insult varies. Cumulative multiple traumas such as drugs, poor nutrition, inadequate prenatal care, violence and neglect are predictive of poorer outcomes (Zuckerman, 1991; Kronstadt, 1991; Werner, 1989).

Magnitude of the Problem

- Children under the age of five are the fastest growing population in foster care. Child abuse reports increased 31 percent between 1988 and 1990. In 1983, approximately 275,000 children were in the foster care system. This number is expected to double by 1995. A large portion of these increases are thought to be due to the introduction of crack cocaine in the mid-eighties (1992 Green Book).

- Compared to other countries, the U.S. now ranks 22nd in the number of infants who die in their first year of life, ranks 31st in the number of low birthweight infants, and ranks 20th in the number of children who die before their fifth birthday. Maternal alcohol,

tobacco, and other drug use is thought to be a contributing factor to infant mortality and morbidity rates (CSAP Perinatal Bulletin, 1992).

- The National Commission to Prevent Infant Mortality (1992) estimates that a 10% reduction in infant mortality and a 25% reduction in low birthweight babies would occur if women stopped smoking cigarettes in pregnancy.

- The National Association for Perinatal Addiction Research and Education estimates that 375,000 children are affected each year by maternal substance abuse (Chasnoff et al., 1990).

Estimates of substance abuse among pregnant women or women of child-bearing ages vary according to the questions asked and definitions used in the research. All estimates, however, indicate a serious and growing problem:

- Of the 59.2 million women of child bearing age (15 - 44) in the U.S., over 4.5 million are current users of illegal drugs, 5.6% use marijuana and 1 % use cocaine. Estimates of use during pregnancy are not known (NIDA National Household Survey, 1991).

- Approximately 59 - 73% of women between the ages of 12 - 34 drink alcohol during pregnancy. (Frank, et al.,1988; Zuckerman, et al., 1989; NIDA National Household Survey, 1990).

- At least 30% of all women in the U.S. smoke at the time they conceive and 25% continue to smoke during pregnancy (Healthy People 2000: National Health Promotion and Disease Prevention Objectives, US Department of Health and Human Services, 1990).

- Perinatal transmission is the leading cause of HIV infection among children, accounting for 84 percent of reported pediatric AIDS cases; HIV infection in women is strongly correlated with intravenous drug use by the mother or her sexual partner, (Children at the Front: A Different View of the Alcohol and Drug War, 1992).

- Approximately 105,000 pregnant women need drug treatment on an annual basis. Only 30,000 women receive at least minimal drug counseling. A fraction of these women receive comprehensive care (Institute of Medicine, 1991).

- At least 167 women in 24 states have been prosecuted for exposing a newborn child to drugs. The 21 cases that have been appealed all have been dismissed or overturned (ABA Journal, 1992).

A number of studies illustrate the scope of the problem. For instance, a study of 36 hospitals across the country conducted by the National Association for Perinatal Addictions Research and Education in 1988 found that on average, 11 percent of pregnant women used heroin, methadone, amphetamines, PCP, marijuana or cocaine. Another study reported that

17% of pregnant teenagers test positive for alcohol and other drugs by questionnaire, provider report or urine screen (Kokotailo et al., 1992). Based on an analysis of the 1988 National Hospital Discharge Survey, the U.S. General Accounting Office (GAO) identified approximately 14,000 infants with indications of maternal drug use during pregnancy. The report, however, states that this figure substantially minimizes the problem because physicians and hospitals do not screen and test all women and their infants for drugs (GAO, 1990).

Bias Toward Poor Women

Studies indicate that poor minority women are more likely to be identified than other pregnant women who are cocaine users. A clinical investigation conducted within Pinellas County, Florida, anonymously tested women entering private obstetric care and women entering public health clinics for prenatal care and found the overall incidence of drug use was similar in both groups (Chasnoff, 1990). A 1990 GAO report found that private hospitals serving primarily non-Medicaid patients screened infants for drug exposure less often than public hospitals. While some researchers have found a prevalence of substance abuse as low as two percent, other studies from inner city hospitals report that as many as half of all pregnant women test positive for illegal drugs. A 1992 Rand study found obstetricians in private institutions chose not to screen their patients for presence of illicit drugs because of limited treatment options and significant costs associated with screening. Private physicians are also fearful of losing patients if it became known that they drug screen their patients. The report concluded that private health care providers are reluctant to participate in detecting and reporting maternal drug abuse (Zellman et al., 1992).

Access to Substance Abuse Treatment

Although the media began reporting stories in 1988 about "tiny maimed infants who either die of their illness or go home to be neglected or abused,"(Griffin, 1989) none reported the lack of substance abuse treatment for the mothers of these infants. A 1990 survey by the National Association of Alcohol and Drug Abuse Directors, Inc. estimated there are 280,000 pregnant addicted women nationwide; less than 11% received substance abuse treatment, and only a fraction receive comprehensive services designed for addicted pregnant women. A survey of 78 drug treatment programs in New York City found that 54% denied treatment to pregnant women (GAO, 1990). One of the primary reasons cited for refusing treatment to pregnant women is the issue of legal liability; we were unable, however, to find one case where a treatment center was sued by a woman who had been addicted during pregnancy.

In general, traditional substance abuse treatment services have been tailored to male addicts, not to women. Thus, substance abuse treatment programs for pregnant women must be reinvented by trial and error, a process that inevitably necessitates more thought, money and time (Kumpfer, 1991). Treatment services for pregnant women are more difficult to establish and operate because women have special needs and because they typically have children who require supervision and room and board. The need to include children in treatment programs has created new problems, including epidemics of childhood communicable diseases and the potential of child abuse within the treatment community.

Treatment needs for pregnant and parenting women are more complex than for men. Many pregnant and parenting women with substance abuse problems have multiple diagnoses and require treatment for hepatitis, tuberculosis, and sexually transmitted diseases, which are difficult

to accommodate within existing treatment programs. Providing ancillary services such as dental care is also problematic because of the high risk of AIDS among drug populations. The delay in obtaining Medicaid benefits also interferes with the procurement of family planning services such as Norplant and tubal ligations.

Women using alcohol and other drugs during pregnancy typically face simultaneous stresses of poverty, addiction, and new motherhood with inadequate support and social resources to assist them. As part of the problem that leads to and results from substance abuse, these women very often suffer from low self-esteem, anxiety and depression. The ability to address these needs requires specialized staff and services.

Establishing treatment centers for addicted pregnant women inevitably confronts the NIMBY (not in my backyard) phenomenon. While the need for substance abuse treatment centers is great, people needing treatment are often seen as undesirable and dangerous. Moreover, communities are often fearful that the presence of substance abuse treatment centers will encourage and foster increased drug use or present dangers for children and other adults. This fear contributes to the maintenance of substance abuse treatment programs as satellites of mainstream medical and social services and ultimately encourages a climate of mistrust and lack of coordination between substance abuse treatment and medical services.

Interagency Coordination And Interdisciplinary Cooperation

In general, primary care providers and mental health professionals lack information about the variety of services that are available to addicted women and their families, and the ways in which programs might overlap or coordinate with each other. In part, this problem arises

because there is no consistent set of categories, no agreed-upon framework in which to identify and evaluate the variety of programs offered by the public and private sectors. For example, institutional coordination of benefits among Medicaid, child welfare, and substance abuse agencies is often lacking or non-existent. Even when financial coordination does exist, lack of treatment options interferes. In general, there is a lack of available beds for women, and pregnant women in particular, resulting in long waiting periods for admission to treatment programs. Lack of transportation and child care also inhibit access to treatment. If children are placed in foster care to accommodate a mother's entry into a substance abuse treatment program, the family loses AFDC and subsequently Medicaid benefits. Because of the punitive laws in many states, women fear losing their children if they seek prenatal care or substance abuse treatment (GAO, 1990).

Lack of Trained Primary Care Providers and Counselors

Most primary care physicians and nurses, including perinatal clinicians, are ill prepared to manage the complex needs of an addicted pregnant woman. Until recently, medical and nursing school curricula were lacking in substance abuse content. For the most part, clinical training in substance abuse treatment is regarded as an unnecessary or optional component even for primary care education. Healthcare professionals who do have appropriate expertise learned their skills through apprenticeship, inservice and continuing education in substance abuse treatment programs. The primary care system and the substance abuse treatment system have different philosophies, clinical training programs, staffing patterns and service delivery. Clinicians in both systems lack skills in interdisciplinary and interagency referral and

cooperation. The result is deficient care for pregnant women who require services from both systems.

Economic Costs

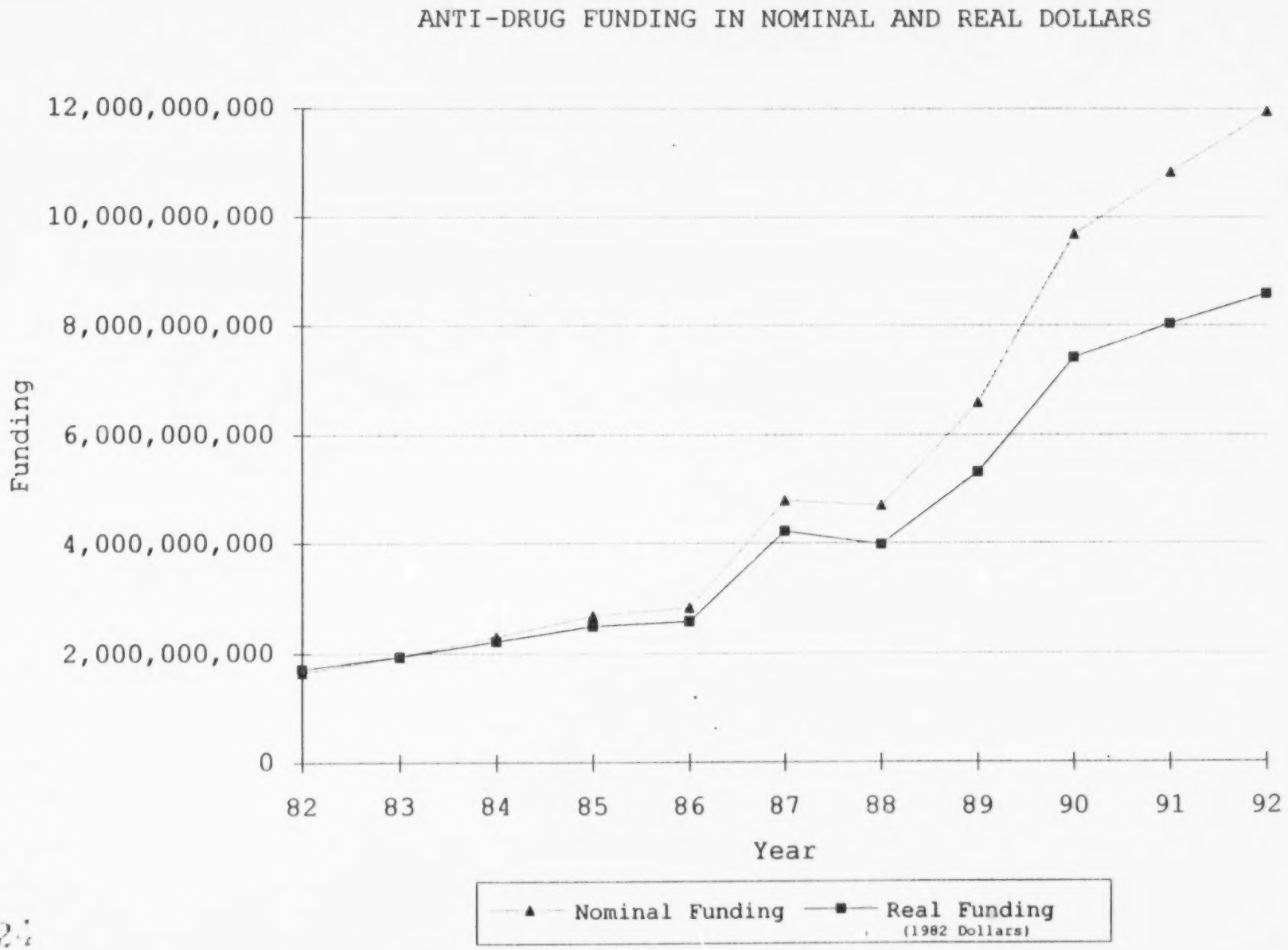
The cost of inadequate healthcare delivery to addicted pregnant women and their families is high both in human and economic terms. In the short term, the economic costs include those for pregnancy complications, preterm labor, low birth weight, child welfare and infant death. Babies with medical problems related to drug exposure require longer lengths of stay in the hospital, often in the critical care unit. The GAO (1990) reports median hospital charges for each drug-exposed infant to be $1100 to $4100 higher than those for non-exposed infants. Other studies estimate hospital costs for cocaine-exposed infants to be $5,200 higher than for nonexposed infants (Phibbs, Bateman, Schwartz, 1991). Over the long term, costs include those related to chronic illness, learning disabilities and impaired children (Phibbs, 1991). According to Chasnoff (1991), national yearly costs of treating drug exposed infants could range from $385 million to $3 billion. By avoiding the need for specialized hospital treatment, special education and welfare services, substantial costs could be saved (Phibbs, 1991).

Government Response

The federal government launched a "war on drugs" in 1986 based on the premise that illegal drug use is morally wrong and unacceptable, and users must be punished. According to the GAO (1990,1991,1992) this program has reduced drug use among casual users and has led to the incarceration of large numbers of drug addicts. It has done little, however, to reduce

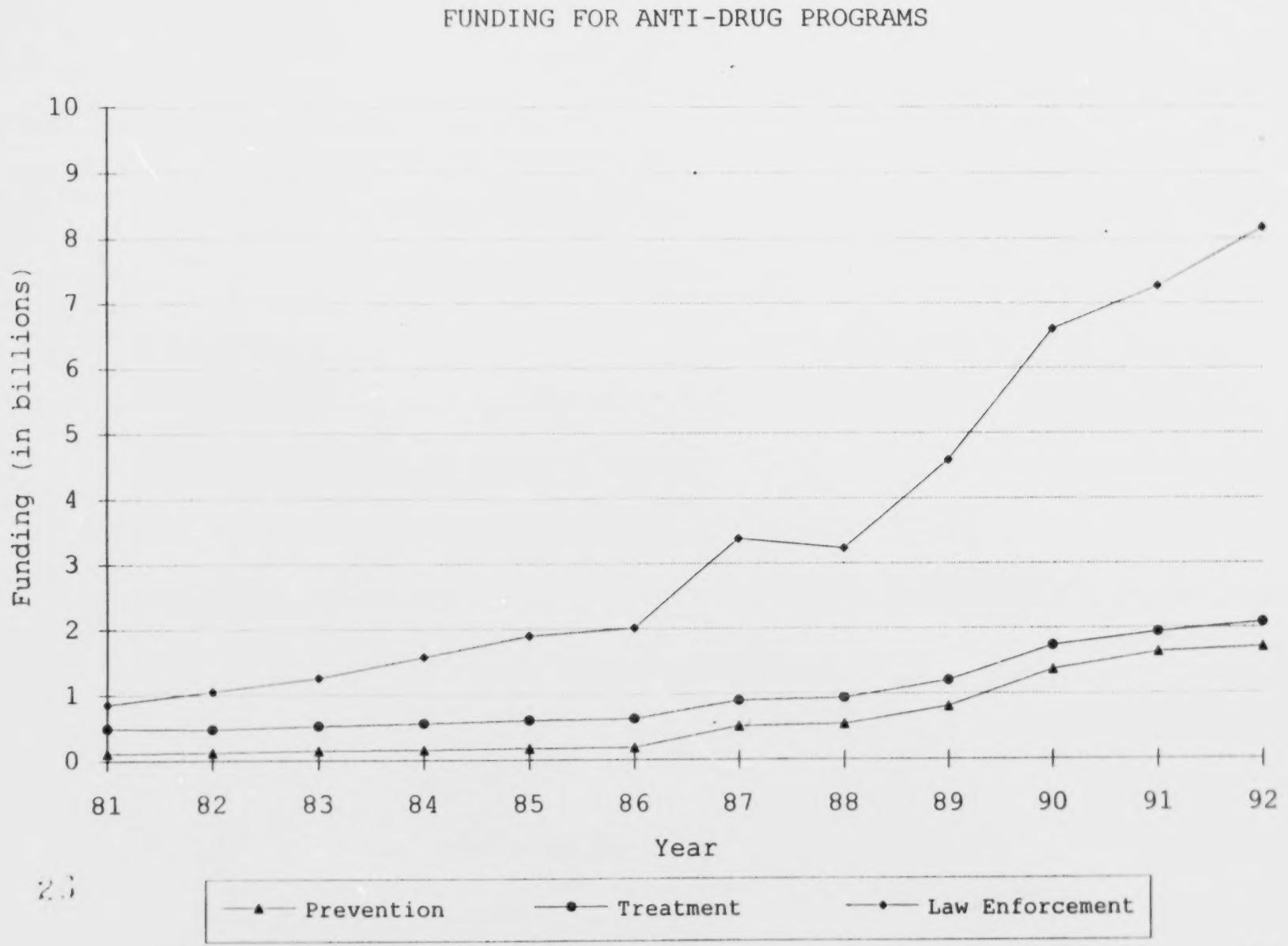
crime or the demand for drugs. Over one million people are incarcerated in the U.S., more people per capita than any other country in the world. This figure represents a doubling of the prison population, including a tripling of the female population, since 1980. This increase is due largely to incarceration of non-violent drug addicts because of the new federal mandatory sentencing laws enforced upon this population. It is estimated that 75% of all federal and state prison and local jail inmates, probationers and parolees need comprehensive drug treatment and aftercare services, but only 1% of federal inmates, 20% of state inmates and less than 10% of jail inmates currently receive services. Figure 1 displays the federal anti-drug funding in nominal and real dollars for the past ten years. Figure 2 shows the federal dollars designated for law enforcement, treatment and prevention. See Appendix A for discussion of the legal system and maternal drug use.

Figure 1



Source: National Drug Control Strategy Budget, 1992

Figure 2



Source: National Drug Control Strategy Budget, 1992

State Laws

The punitive philosophy underlying the federal war on drugs has also influenced state legislatures. According to the American Bar Association Journal, 8 states now have mandatory reporting laws for evidence of drug exposure in newborns as child abuse, which could lead to the child's removal and the termination of parental rights (Adirim, 1991). The Office of Inspector General reported that seven state laws define substance exposed infants as abused, neglected, harmed, or in need of services. Three states mention toxicology testing in their child welfare laws (DHHS, Office of Inspector General, May, 1992). There is no empirical evidence that such legislation either deters maternal substance use or improves infant mortality or morbidity. At least one study suggests that pregnant women continue to have access to drugs even while incarcerated (Chasnoff, 1991). Although the TASC (Treatment Alternatives to Street Crime) model have been developed to identify, evaluate and refer substance abusing offenders to treatment as alternative to incarceration, none of these programs have been specifically designed for pregnant women. See Appendix A for the discussion of TASC.

Most prison and jail systems do not have well-established linkages with the healthcare system. This raises questions about how drug withdrawal is managed, since the withdrawal syndrome can be damaging to an unborn child. The American Nurses Association (1991) and the American College of Obstetricians and Gynecologists (1992), whose members treat addicted pregnant women and their children, have position statements opposing criminal prosecution of these mothers.

Nevertheless, 167 women in 24 states have been prosecuted for exposing a newborn child to drugs because of drug use during pregnancy. Twenty-one of those cases have been dismissed

or overturned when challenged or appealed (Center for Reproductive Law & Policy, 1992). We were unable to find any other country in the world that presently has similar policies regarding addicted pregnant women.

According to an Intergovernmental Health Policy Project (IHPP)(1992) report, seventy-two bills relating to substance abuse and maternal and child health issues were introduced in 23 states during 1992. Specific substance abuse areas addressed include: Fetal alcohol syndrome; mandating health professionals, educators and community outreach workers to counsel pregnant women about the dangers of using drugs alcohol, and tobacco; screening newborns and pregnant women for the presence of substances; point-of-purchase warning sign requirements; and the formation of committees to study the extent of the problem of addicted women and their babies and how best to help them. The National Association for Perinatal Addiction Research and Education interprets these actions as a trend away from legislation which is punitive toward laws which encourage treatment and appropriate intervention (Adirim, 1991).

Federal and state governments have also encouraged substance abuse treatment programs for pregnant women within the past five years through federally funded demonstration projects and federal block grant money set asides. These grant programs are subject to Congressional appropriations on a time limited basis. Most of the grants are non-renewable and extend for 3 to 5 years. The intent of demonstration grants is to provide limited support for innovation and research for projects that will eventually be assimilated into the service delivery system and financed through a stable source. However, with addicted mothers-to-be, the sources for continuation funding are very limited.

Private Sector Response

Private foundations, corporations and individuals have also funded activities concerned with drug-exposed children. Most efforts are concentrated on the infants with very little focus on the family as a whole. Grants that do target addicted pregnant women are focused on prenatal care rather than comprehensive services.

As states, cities, communities and both public and private institutions grapple with the immediate financial, medical and social needs of substance abusing women, policymakers have struggled with the problem by developing an array of programs for treatment as well as prevention. Budget deficits, increasing mandates and other pressing responsibilities, however, have resulted in a confusing plethora of programs and policies that may or may not be coordinated institutionally, financially or medically.

METHODS

The process of generating data for this report was as informative as the findings. The task of identifying comprehensive programs and tracking funding sources through traditional methods of literature review and survey yielded very little. Information was fragmented, difficult to access and unstable.

Literature Review

The literature, like the services, is fragmented and focused on discrete aspects of the problem. For example, most investigators in perinatal addiction are obstetricians, pediatricians or developmental psychologists, and the treatment outcomes they have studied have been limited to drug effects on babies and obstetrical complications. Moreover, the studies that have been done contain small clinical samples that cannot be generalized.

Epidemiologic research is severely lacking. Estimates on the numbers of drug-exposed children and addicted pregnant women in this country vary, and states are unable to give accurate statistics on numbers of pregnant women or drug exposed children who need services.

Most literature on clinical research and effective treatment methods are based on treatment of male addicts. Although it is common to apply that research to women, there is evidence that this application is inappropriate. For instance, most of the measures for screening for addiction per se or addiction severity used in treatment research have been developed on male populations and do not completely reflect the female experience.
Likewise, measures for infant assessment have also been developed for babies of non-addicted mothers.

Surveys

The ability to use survey methods to identify funding streams and funding levels is impaired by the way in which funding information is recorded. There is no one source for such data within most states. First, Medicaid reimbursements, the most common way to fund medical care for indigent families, are not tracked specifically for addicted pregnant women with children. Second, funding sources that target this population are fragmented and poorly documented. In addition, various state and local agencies which fund substance abuse treatment for indigent people typically do not case manage or coordinate referrals or services, making it difficult to ascertain the exact services or budget expenditures used for addicted pregnant women and their children. Major sources of funding for this population such as Medicaid, Child Protective Services and block grant programs, all have their own processes for identifying and classifying recipients in need of treatment and referring them to community service, and in most states these processes are not coordinated with each other.

Networks and Personal Contacts

Data collection for this project relied heavily on personal contacts and established networks. We began with telephone interviews with knowledgeable federal government officials who provided us with names and telephone numbers of people who work on the issue of drug-exposed children and their families. These contacts led to national meetings, invitations to consensus deliberations, and more contacts. We traveled to Chicago and Florida. We collected many reports, some official and some in draft form. It was through this process that we were able to identify exemplary models of treatment and to search out exactly how these programs

were funded. This process was critical, as all comprehensive models of treatment use more than one source of funding to sustain their services.

Data Base Information Systems

The Resource Center for the Prevention of Perinatal Substance Abuse, established in 1992 by a $15 million contract from the Federal Office of Substance Abuse Prevention (OSAP, now CSAP) to Lewin/ICF (now Lewin/VHI), which disseminates information through the Perinatal Research and Education Management Information System (PREMIS), and the OSAP National Clearinghouse for Alcohol and Drug Information, provided us with state of the art information on perinatal alcohol, tobacco, and other drug use prevention programs and strategies, the current literature and research, and new funding sources. Other federal agencies, such as the Department of Justice and the Department of Transportation, have their own data base information systems for drug related programs which contained related material.

Consensus Building

The Resource Center for the Prevention of Perinatal Substance Abuse engaged in a major consensus building and information gathering process. We participated in several closed workshops as one of the experts, along with key service administrators and project grantees who serve addicted pregnant women and their families. By participating in this process and listening to the providers, many of them recovering people themselves, we began to understand exactly what these families need and to appreciate how creative administrators had to be to fund services to meet these needs.

Sources For The Comprehensive Model, Objective 1

The model is based on information from key state and federal agencies concerned with substance abuse prevention and treatment. The sources included published research, conference proceedings, and special analyses. The contributing agencies included four agencies within the Department of Health and Human Services (HHS), the New York State Division of Substance Abuse Service and the National Association for Perinatal Addiction Research and Education (NAPARE).

Three lists of comprehensive services from key government agencies were used to develop the CHPR model:

1. The Office of Treatment Improvement (OTI) Criteria for Comprehensive Treatment;
2. The New York State Division of Substance Abuse Services, Comprehensive Core Services for Residential Programs for Substance Abusing Women and Their Children; and,
3. The priority list of services deemed most essential by the experts who participated in the OSAP (now CSAP) National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs Exemplary Workshop.

Appendices B, C, and D contain the complete lists of services from these three sources. These lists enumerate specific services within broad categories; however, the names of the services are not consistent across the three lists. Services which were repeated across all three sources or were identified in the literature or in consultation with experts in the field, were condensed into conceptually consistent categories.

Objective #1. Develop a consensus document on a service delivery model that provides an appropriate continuum-of-care of comprehensive medical, social and support services for at-risk or drug-exposed infants and their families.

The development of a comprehensive model of care for drug-exposed children and their families requires some notion of who these families are. As part of our investigation, we listened to reports and discussions among the principal investigators from many of the NIDA and CSAP demonstration projects. The profile of the typical addicted mother-to-be that emerged from these projects was as follows:

1. Average age 27-28
2. High school dropout
3. History of physical abuse and family violence
4. Current anxiety and depressive disorders in addition to substance abuse
5. Currently physically or sexually abused
6. 3 or 4 other children
7. Partner also involved in drug abuse
8. Homeless or living in drug using environment

The CHPR Comprehensive Model is built on the assumption that infants have a sequence of developmental tasks to accomplish, each dependent on successful mastery of the earlier task, and that the mother has an indispensable role in this process. Drugs can disturb either side of this relationship. Prenatal drug abuse interferes with the normal regulation of the infant's prenatal physiologic processes, and postnatal drug abuse impairs the mother's ability to

communicate and respond to the infant. Children need a nurturing mother and a safe environment. Services that improve an addicted mother's chances to live a drug-free existence enhance the child's chances to grow and develop normally. Services that prevent or treat a child's developmental delays strengthen the potential for a healthy relationship between mother and child (OSAP Prevention Monograph-11, 1992).

Utilizing the sources described in the Methods section, we determined the points of entry for the families and then identified the range of community services that might be needed. Each of the services was listed and categorized according to function, after which they were analyzed according to how they related to each other.

An addicted pregnant woman typically will be identified through child protective services if the children in the family are thought to be neglected or the baby tests positive for drugs at the time of delivery. If the family is homeless or without food, they will need services to address hunger and safety before they will need substance abuse treatment. Once the mother is detoxified and treated for substance abuse, she will need skills to help her live a drug-free life. She may need language and literacy skills, and communication assistance with providers or services. She may need education in parenting, life-skills, and employment skills as well as support and information concerning how to negotiate the numerous public and private systems that can provide assistance. She may need access to a telephone to call for appointments or to notify agencies where the family is living.

Once the services were organized in a time sequence or according to when the family may be ready for services, categories emerged as building blocks. Services within the model build on each other, and the strength or weakness of one service has the ability to weaken the

effectiveness of other services. Interagency linkages and coordination and case management were added to maximize the synergistic potential of the services. Transportation and childcare are integrated throughout the model to improve access and compliance with treatment.

Theoretical Framework

The guiding principles of Abraham Maslow's work (1954) were used as the theoretical framework for the model. Maslow's Hierarchy is built on two fundamental premises: (1) people's needs depend on what they have, and they are motivated only by needs not yet satisfied; (2) people's needs are arranged in a hierarchy of importance. Figure 3 demonstrates the application of Maslow's Hierarchy of Needs to the CHPR Comprehensive Model of Care for Drug Exposed Infants and Their Families. As shown in Figure 3, there are five need categories: (1) physiological needs, (2) safety and security needs, (3) affection and social activity needs, (4) esteem and status needs, and (5) self-realization needs. Figure 4 displays the model components arranged according to Maslow's hierarchy of needs. Basic physiological needs begin at the left side of the page and progress to higher needs, such as esteem and self-fulfillment, on the right. The basis for Maslow's theory is that lower needs must be satisfied before higher needs can be addressed. The effectiveness of the services on the right side of the model are therefore dependent on the strength of the services on the left. Figure 5 displays two services, case management and transportation, which are critical components of the service delivery model and allow the drug-exposed infant and their families to make the transition from one stage to the next.

Figure 3

MASLOW'S HIERARCHY OF NEEDS APPLIED TO THE COMPREHENSIVE SERVICE DELIVERY MODEL

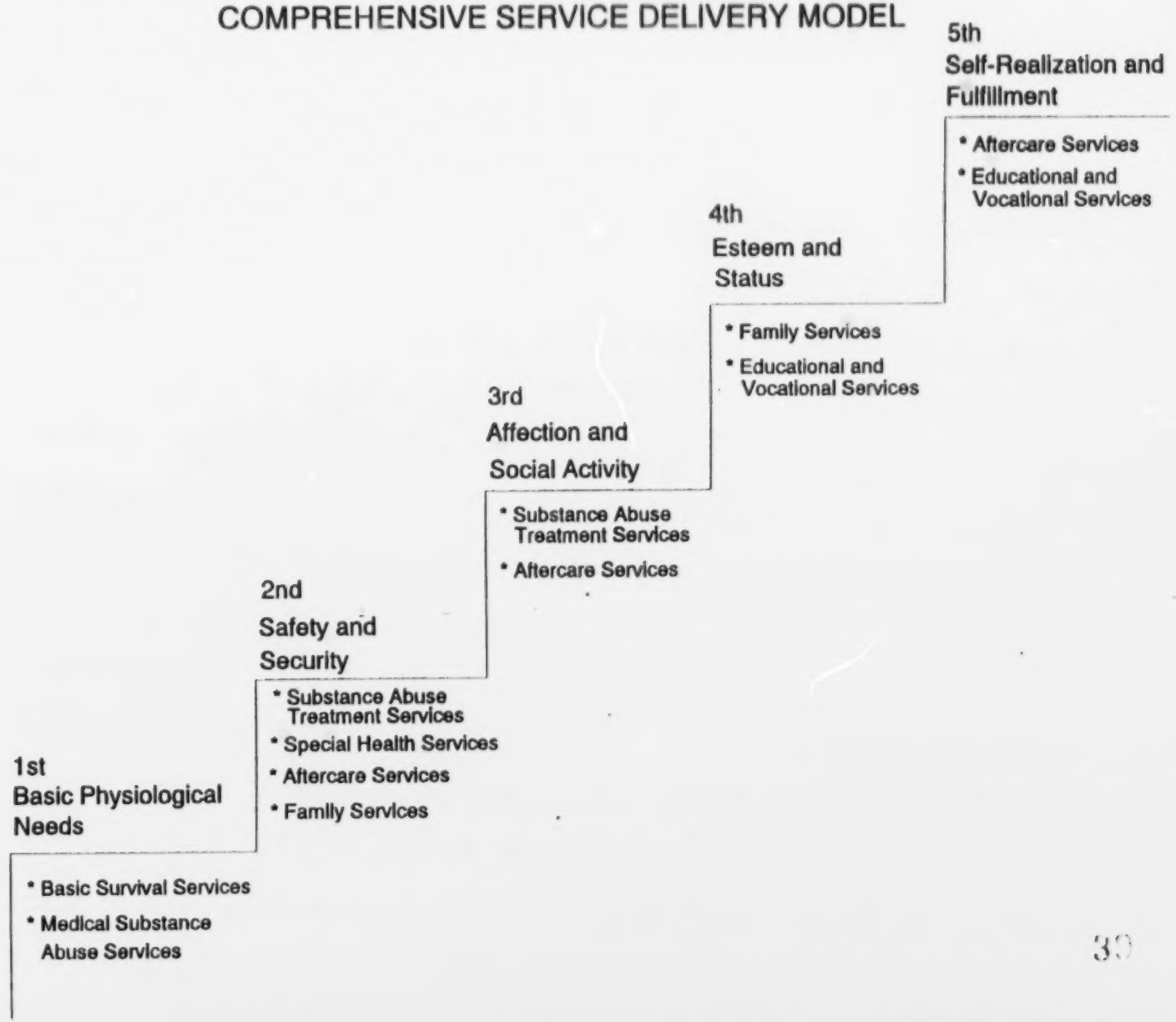


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Figure 4

CHPR COMPREHENSIVE SERVICE DELIVERY MODEL

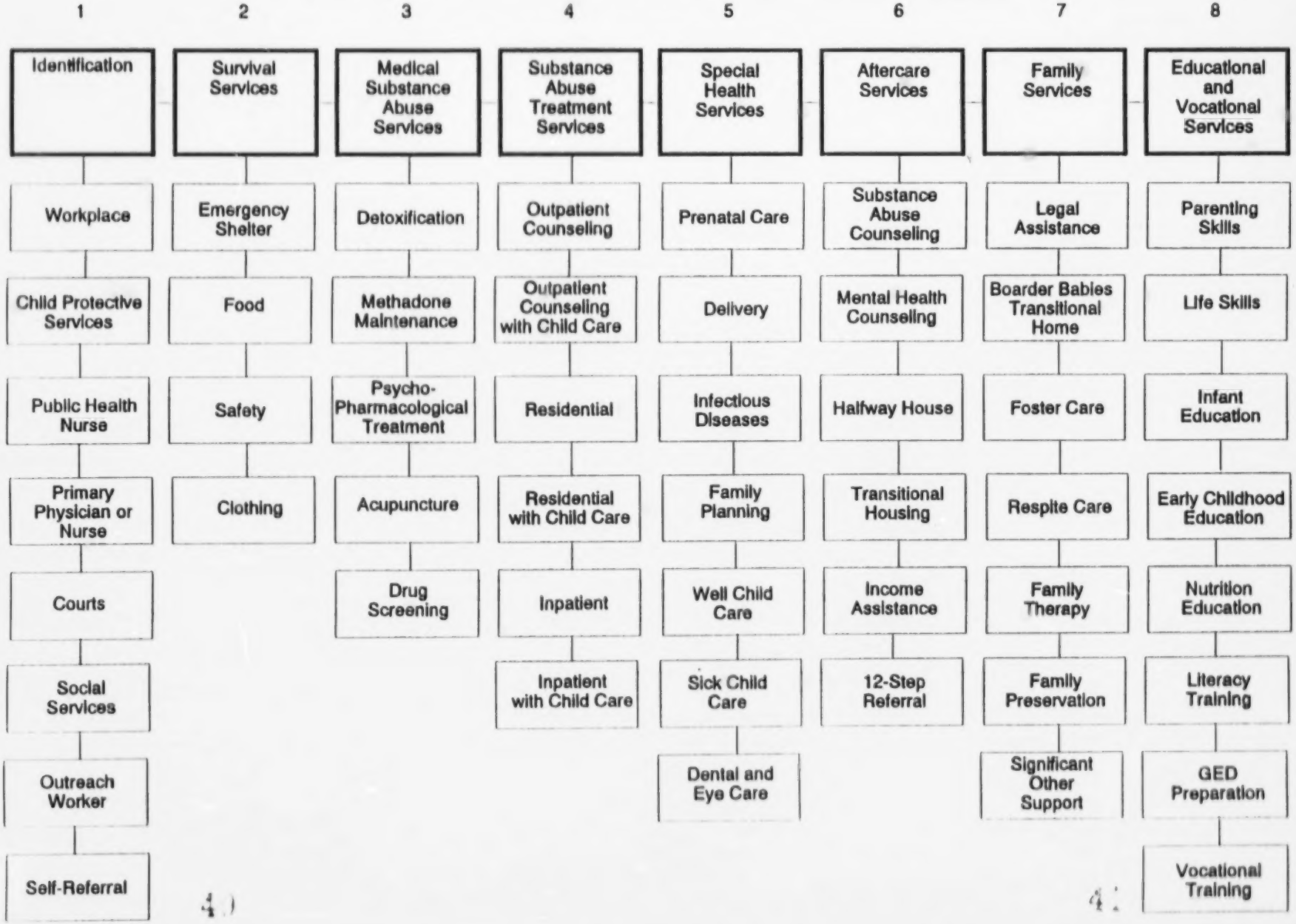
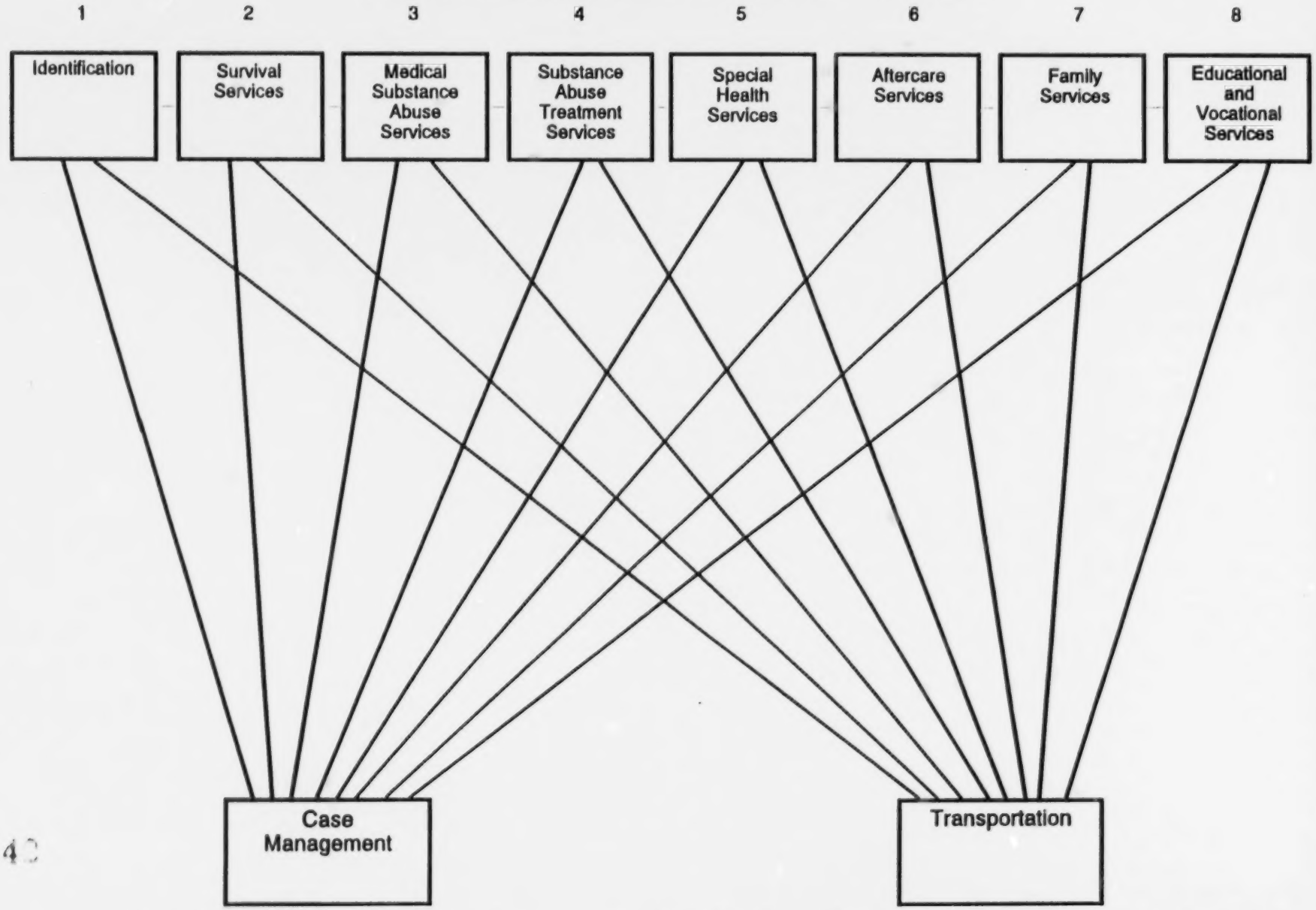


Figure 5

COMPREHENSIVE SERVICE DELIVERY MODEL



Transportation and Case Management services are critical components of the service delivery model and allow the drug-exposed infant and their families to make the transition from one stage to the next.

Maslow's categories of needs are:

1. Physiological needs consist of basic survival requirements such as food, water and shelter. The characteristics of addicted pregnant women identified as cocaine abusers indicate they often have basic needs for housing, food and drug free housing. Many are homeless without employment or family support. The services that correspond to these needs are represented in column 2 of the model, Survival Services.

2. Safety and security needs include shelter and protection from physical harm and deprivation. In addition to prenatal and obstetrical care, as well as substance abuse treatment, almost all identified pregnant addicted women need treatment for medical and psychological problems due to physical, sexual, and emotional abuse sustained in childhood and their current living circumstances. The services that correspond to these needs are represented in Columns 3, 4, 5, 6, and 7: Medical Substance Abuse Services, Substance Abuse Treatment Services, Special Health Services and Aftercare Services.

3. Affection and social activity needs include belonging to a group and giving and receiving friendship and affection. This transitional level builds on satisfaction of physical needs and begins to address the individual's emotional needs. Imbedded in the components for Substance Abuse Treatment Services and Aftercare Services are treatment modalities that specifically address the need for affiliation and affection.

4. Esteem and status concerns include self-respect or self-esteem resulting from an

awareness of one's importance to others. Substance abuse as a pattern of living that is passed from generation to generation is well established in the literature. Many women have never had adequate parenting themselves and need "re-parenting" if they are ever to function as productive human beings and loving adults. Re-parenting is accomplished through bonding with professional caregivers who model good parenting, and demonstrate respect and cultural sensitivity. This modeling occurs with everyone from an administrator of the program to a van driver who drives the women to and from outpatient services. Esteem needs point to the necessity for all service providers to be committed, flexible, well trained and aware of the potential of their interaction with families.

Parenting skill training is necessary to educate the woman in ways to nurture herself and her family, and to achieve self-esteem and independence. The services that correspond to these needs are represented in last two columns of the model: Family Services and Educational and Vocational Services.

5. Self-realization needs include achieving full development of one's potential. To achieve this step in the hierarchy, the woman is aided by transitional housing and income assistance which are components of the Aftercare Services and literacy training, GED preparation, and vocational training. These important services are necessary to assist the woman in functioning in society as an independent citizen with the tools to reach her full potential.

Objective #2: Develop a Compendium of Funding Sources and Programs Across the Fifty States.

GOVERNMENT FUNDING

There is no single, long-term, flexible funding source at either the state or federal level that allows service providers to provide comprehensive services to drug-exposed infants and their families. What follows are highlights of our findings, supported by our analysis and confirmed in the literature.

State government

- State governments deliver prevention and treatment of alcohol and other drug services through state revenues or block grants, although the level of support varies considerably from state to state (NASADAD, November, 1991).

- States provided $1.4 billion[1] or 47.6 percent of the expenditures for alcohol and drug abuse treatment, prevention and other related services (NASADAD, November, 1991).

- According to a General Accounting Office (GAO) report, however, states are not able to identify the number of pregnant women in need of treatment. Without this information,

[1] NASADAD financial data includes only those programs which receive funds administered by the state alcohol and drug abuse agency.

states cannot determine if the services they were providing are sufficient to meet the needs of pregnant women or mothers with young children (GAO, May, 1991).

Federal government

- In recent years, the amount of funding for anti-drug activities provided by the federal government has increased significantly from $1.5 billion in FY 1981 to $12 billion in FY 1992 (ONDCP, 1992). Of this, 68 percent goes for law enforcement, 14 percent goes for prevention and 17 percent goes for treatment in FY 1992 (ONDCP, 1992).

- Most traditional funding streams are categorical by nature and are tied to a specific service. They cannot be used to support diverse services, such as transportation and drug testing services (DHHS, January, 1991).

- Currently, more than three dozen Federal agencies are involved in some aspect of anti-drug activities. No formal relationships to coordinate activities exist among these agencies (CRS, September, 1992).

- More than 75 committees and subcommittees, both authorizing and appropriating, have jurisdiction over issues related to anti-drug activities (CRS, September, 1992). Like the Federal agencies, the jurisdictional boundaries on which the committee system is built

encourages competition for resources (Falco, 1992).

- The largest source of federal funding for prevention and treatment of drug abuse has been and continues to be the alcohol and drug abuse block grant. In 1992, the block grant awarded $1.36 billion to states for anti-drug activities.

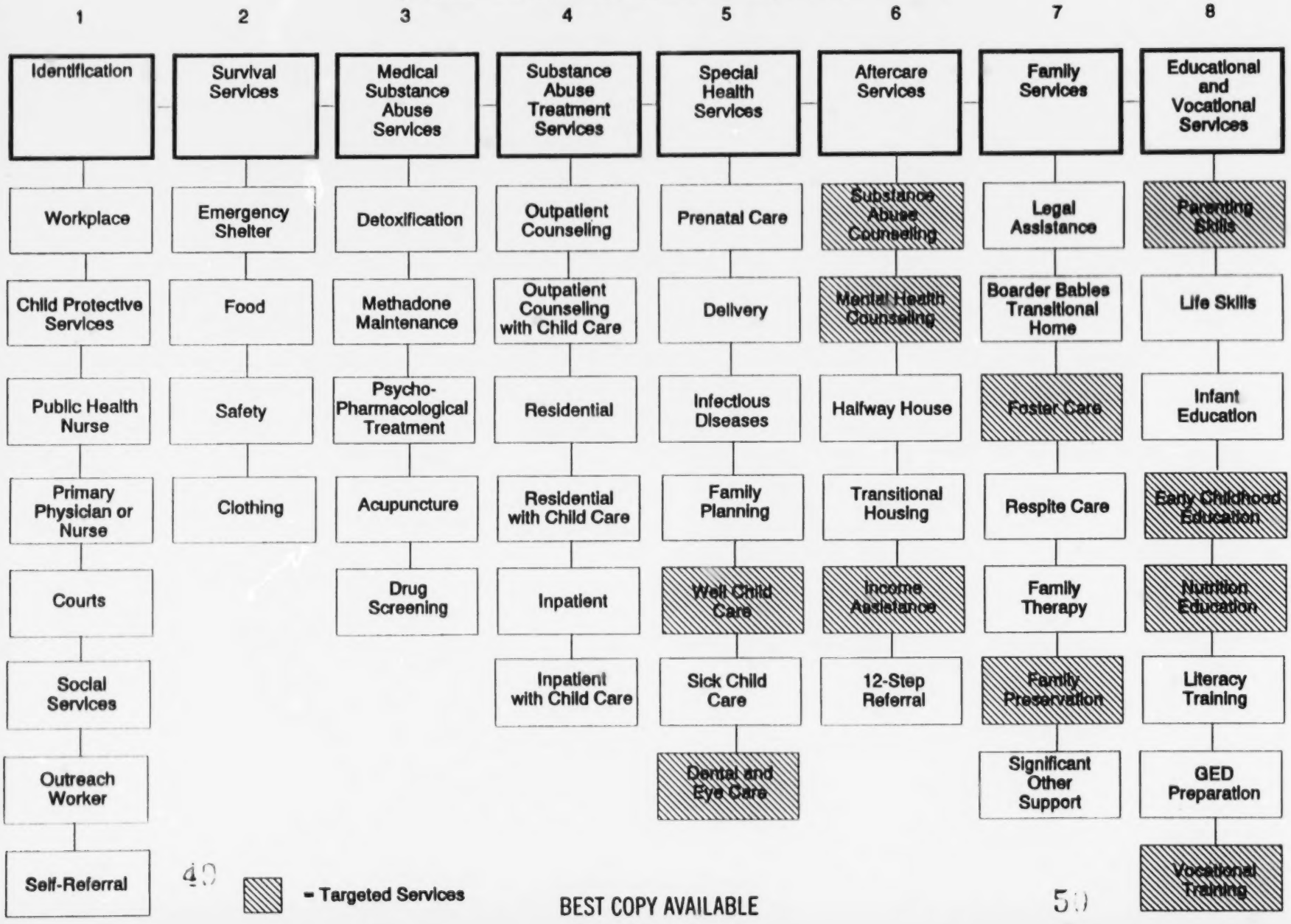
- Medicaid, perhaps one of the most stable sources of funding for substance abuse services, is difficult to access.

- Research is no longer the driving force behind drug policy decisions (Falco, 1992). Thus, drug treatment research has been limited to short-term demonstration projects. The "demonstration" nature of funding for prevention and treatment of substance abuse services for women, particularly women with infants, has impeded long-term planning, continuity and growth.

- Although the Office of National Drug Control Policy (ONDCP) has the responsibility for coordinating drug control policy, it lacks the authority to direct and enforce the efforts of the three dozen Federal agencies or to influence the 75 committees and subcommittees on Capitol Hill. As a result, no long-term planning is taking place nor has one strategy been embraced (Falco, 1992).

Figure 9

ADMINISTRATION FOR CHILDREN AND FAMILIES
(Foster Care, Head Start, Family Preservation)



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Sources For Identification Of Funding Streams, Objective #2

The compendiums of funding sources for the federal departments and agencies represent the compilation of information from a variety of sources including: The Perinatal Resource and Education Management Information System (PREMIS), Federal Register announcements, conference materials, personal communication with agency representatives, federal government and private-sector newsletters, published reports, the Office of National Drug Control Strategy budget, and Hill briefings. Funding sources for each of the foundations were the directories of The Foundation Center, foundation annual reports and in depth interviews with foundation personnel.

GOVERNMENT SOURCES OF FUNDING

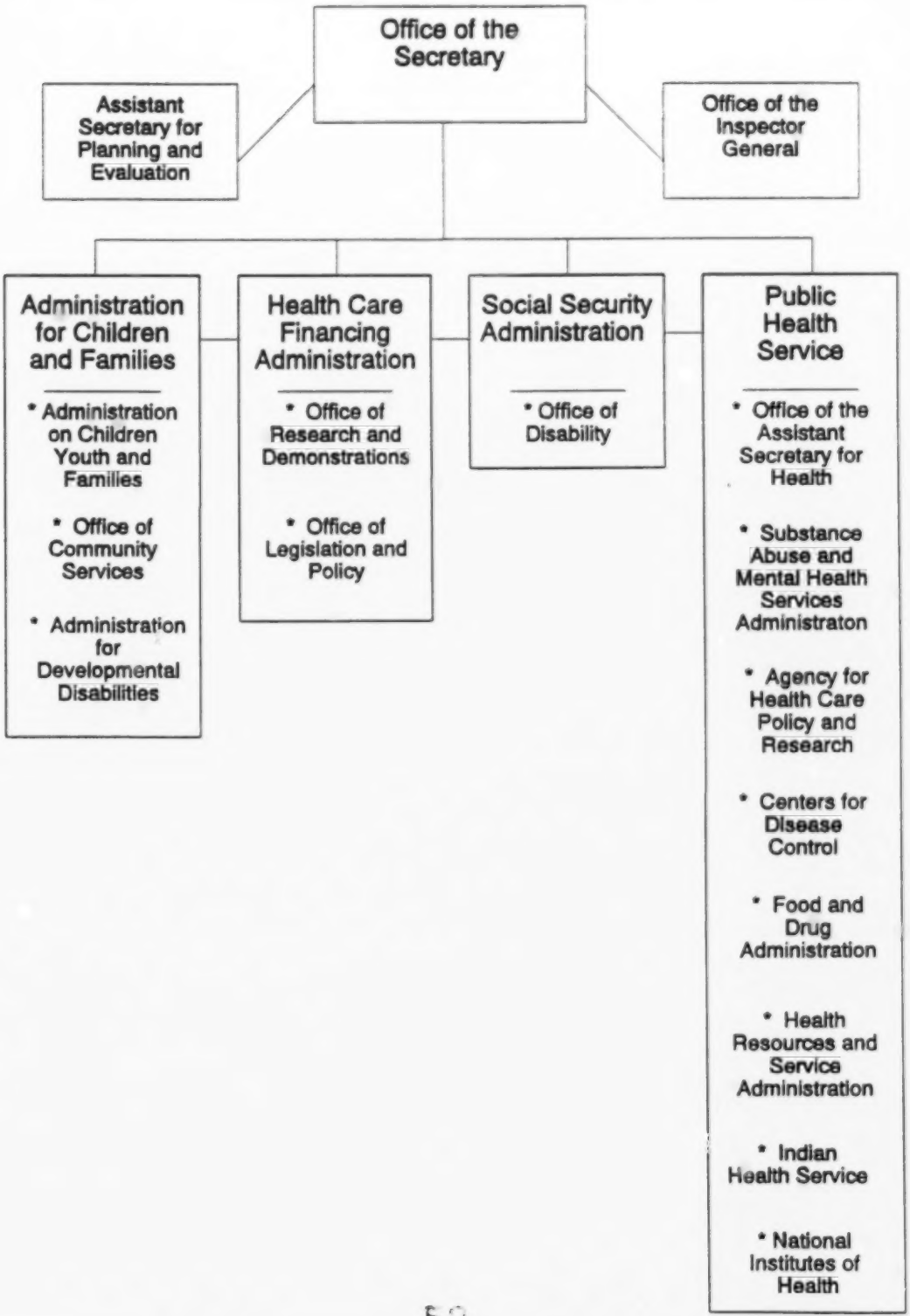
The U.S. Department of Health and Human Services (HHS) is the major source of funding for drug-exposed infants and their families. Figure 6 displays the major agencies within HHS concerned with this issue. Within the Public Health Service (PHS), the Substance Abuse and Mental Health Services Administration (SAMHSA) is the source of funding for block grant and demonstration project money. The National Institutes of Health (NIH) is the source of funding for research projects. The Health Care Financing Administration (HCFA) oversees Medicaid, and the Administration for Children and Families (ACF) administrates welfare and Headstart funding.

In our investigation, we analyzed over 250 different government agencies and foundations. What follows is the compendium of major sources within HHS that target services for drug-exposed infants and their families. See Appendix E for the compendium of additional

Figure 6

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCIES ADDRESSING DRUG-EXPOSED INFANTS AND THEIR FAMILIES


Office of the Secretary
Assistant Secretary for Planning and Evaluation
Office of the Inspector General
Administration for Children and Families
* Administration on Children Youth and Families
* Office of Community Services
* Administration for Developmental Disabilities
Health Care Financing Administration
* Office of Research and Demonstrations
* Office of Legislation and Policy
Social Security Administration
* Office of Disability
Public Health Service
* Office of the Assistant Secretary for Health
* Substance Abuse and Mental Health Services Administraton
* Agency for Health Care Policy and Research
* Centers for Disease Control
* Food and Drug Administration
* Health Resources and Service Administration
* Indian Health Service
* National Institutes of Health

government and private sources that do not target but could potentially fund components of the CHPR Comprehensive Service Delivery Model. Federal agencies such as Department of Transportation and Department of Labor are not included because their funding priorities preclude this population.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
FUNDING SOURCES WHICH TARGET SERVICES FOR DRUG-EXPOSED INFANTS AND THEIR FAMILIES

PROGRAM	DESCRIPTION	FUNDING SOURCE	FUNDING (millions) FY90	FY91	FY92
Abandoned Infants Assistance Program	These demonstration projects are designed to (1) prevent the abandonment in hospitals of infants and young children; (2) identify and address their needs, particularly those who are infected with AIDS or have been prenatally exposed to drugs; (3) assist children to find residences (4) provide respite care; and (5) recruit and train caregivers. In FY91, for example, nearly 100 grants were awarded to train child protection staff to identify and intervene with children at risk of abuse and neglect by drug-using parents and to test innovative strategies for resolving family crises where drugs are involved.	ACF	$9.9 m	$12.6 m	$12.6 m
AIDS Comprehensive Outreach Demonstration Project	These demonstration projects evaluate the effectiveness of alternative strategies for reaching drug users and their sexual partners. They are provided with AIDS education materials and persuaded to enter drug treatment and other needed services. Several strategies specifically address pregnant women and their children.	NIDA OTI	$31.0 m	$13.0 m	$10.3 m
Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant	Funds in this program are passed to the states which use the money to provide alcohol, drug abuse and mental health treatment, prenatal care, child care, housing, job training, prevention and intervention services to target populations. In 1984, Congress required states to use at least five percent of the total block grant to provide new or expanded alcohol and drug abuse services to women. In 1988, the amount states must spend on services designed for women (especially pregnant women) and dependent children was increased to 10 percent. In FY91, for example, the set-aside for women totaled $126.9 million. These grant funds are the primary long-term funding source for Federal support to the states for the publicly-supported treatment and prevention programs within each state.	OTI	$1.2 b	$1.3 b	1.4 b

Capacity Expansion Program	Grants are awarded to states in which the demand for substance abuse treatment services exceeds the current capacity for providing treatment services. States, in turn, will grant funds to treatment providers. Special emphasis is placed upon expanding treatment capacity for high-risk populations, particularly pregnant and postpartum women and their drug-exposed infants. These grants replace the drug treatment waiting list reduction grants. For FY92, none of the money came from OTI's budget; instead it came from the Office of the National Drug Control Policy's Special Forfeiture Fund.	OTI	-	-	$ 9.0 m
Child Welfare Research and Demonstration	This program supports research and demonstration projects in the area of child and family development and welfare, particularly to address preventive services, foster care, family reunification and adoption. Projects are funded to demonstrate ways to meet the immediate non-medical needs of drug-exposed infants and HIV-infected children. In FY 91, for example, grants were awarded to develop models of specialized foster care for drug-exposed infants.	ACF	$7.5 m	$6.7 m	$6.7 m
Child Welfare Training	Discretionary grants are awarded to institutions of higher learning to develop and improve education and training programs and resources for child welfare providers. Activities supported include upgrading information related to the effects of drug abuse.	ACF	$3.6 m	$3.6 m	$3.6 m
Cooperative Agreement Research Demonstration Program for Alcohol and Other Drug Abuse Treatment for Homeless Persons	This demonstration project focuses on assessing the efficacy of a variety of client-centered interventions targeted to homeless persons with alcohol and other drug problems. Women with children are among those who are targeted to receive services. The funding levels shown include funds appropriated for the other research demonstration program, Community Grant Projects for Alcohol and Other Drug Abuse Treatment of Homeless Individuals.	NIDA NIAAA	$16.4 m	$16.4 m	$16.0 m
Cooperative Agreements for Drug Abuse Treatment Improvement - Campus Treatment Program	These cooperative agreements are part of OTI's Treatment Improvement program. Cooperative agreements were awarded to two states (New Jersey and Texas) to conduct residential drug abuse treatment centers in campus settings for the purpose of demonstrating one-stop shopping. All campus facilities must offer treatment to at least one of the following groups: pregnant women, women and their children, racial and ethnic minorities, and adolescents.	OTI	-	$17.2 m	$18.0 m

Cooperative Agreements for Drug Abuse Treatment Improvement in Crisis Areas (Target Cities) Program	These cooperative agreements are funded under the Treatment Improvement program. Cooperate agreements are awarded to states with critical drug abuse treatment needs to help in areas such as the improvement of delivery, accessibility and effectiveness of treatment services, the strengthening of the drug treatment infrastructure and the fostering of coordination and collaboration among local treatment programs. Nine cities have received awards: Albuquerque, Atlanta, Baltimore, Boston, Los Angeles, Milwaukee, New York, Philadelphia and San Juan. Funds are used specifically to serve critical populations such as perinatal women and drug-exposed infants.	OTI	$28.5 m	$29.0 m	$33.5 m
Crack Babies Program	Grants are awarded to develop and provide respite care for babies, including those who are drug-exposed and those with AIDS	ACF	*	$5.9 m	$5.9 m
Demonstration Grants for the Prevention of Alcohol and Other Drug Abuse Among High Risk Youth	This program provides funds to develop innovative approaches aimed at preventing alcohol and other drug use among youth. Funded projects are designed to identify and enhance protective factors while reducing the risk factors for using alcohol and drugs.	OSAP	$32.8 m	$45.5 m	$52.0 m
Emergency Protection Grants for Children of Substance Abusers	This program provides grants to state and local family-serving agencies to expand or implement emergency protective services for children whose parents are substance abusers.	ACF	-	$19.5 m	$19.5 m
Extending Medicaid Coverage of Substance Abuse Treatment to Eligible Pregnant Women: Assessment of Issues and Costs	This purpose of this research project is to study Medicaid's coverage of substance abuse treatment programs and assess the costs of expanding this treatment to pregnant women who are at risk of delivering drug-exposed infants. The study is funded at $168,551 from August 1990 to April 1993.	HCFA	$.17 m	-	-
Improving Access to Care for Pregnant Substance Abusers (Medicaid Demonstration)	This demonstration project seeks to increase the number of Medicaid-eligible pregnant substance abusers who receive coordinated perinatal care services and substance abuse treatment. Projects were awarded to state Medicaid agencies in five states: Maryland, Massachusetts, New York, South Carolina, and Washington. Services that are not currently available in the state Medicaid plans are also included in some of the demonstration sites. For example, residential treatment services in institutions for mental diseases (IMDs) are available at three sites. Approximately $6 million will be available for all projects over the life of the demonstration.	HCFA	$0	$6.0 m	*

National Resource Center for the Prevention of Perinatal and Other Drug Abuse	Begun in 1991, this $15 million Center serves as a national focus for policy, research, information dissemination, training, leadership development, service design, technical assistance, and evaluation findings of programs targeting substance abusing pregnant and postpartum women and their children. The Center develops and disseminates promising and innovative prevention, treatment, and rehabilitation practices, as well as act as a catalyst for mobilizing communities and the nation to address the problems and negative health consequences of perinatal drug use.	OSAP	-	$5.0 m	$5.1 m
NIDA Research Demonstration Grant Program	One example of these projects is what is commonly known as the "Perinatal 20" project. This project aims to evaluate the short-term and long-term effectiveness of 20 comprehensive drug abuse treatment programs designed for drug-abusing women of childbearing age and their children. These programs provide a broad range of social and health care services including prenatal and postnatal care, residential and outpatient treatment, psychotherapy, counseling, educational and vocational training and long-term case management. What is being tested is the relative effectiveness of adding one specific non-treatment service to an existing treatment program. For example, do women in residential treatment with on-site child care have better outcomes than women who are separated from their children during treatment? It is anticipated that 6,000 women and 3,000 children will be treated over the six year period. The funding levels shown are the total funding amounts for extramural research demonstrations.	NIDA	$97.2 m	$105.6 m	$108.0 m
Pediatric AIDS Health Care Demonstration Grant Program	These projects demonstrate effective ways to prevent HIV infection, especially through the reduction of perinatal transmission, and to provide treatment and support for infants, children and youth with infection. Emphasis is placed on care delivery in ambulatory settings, using a case management approach which will reduce the time spent in hospital settings. Many pediatric AIDS patients are also drug-exposed. This project is supported by funding provided through the Special Projections of Regional and National Significance (SPRANS) program.	MCHB	$14.8 m	$19.5 m	$19.7 m
Policy Research Regarding Substance Abusing Women and Their Children	ASPE has ongoing studies related to maternal substance abusers and their children. Past efforts have included (1) an analysis of model programs serving drug-exposed children and their families, and (2) the development of materials for pre-schools and elementary-schools regarding the educational needs of drug-exposed children.	ASPE	*	*	*

Pregnant and Postpartum Women and Their Infants Demonstration Program	Public and private profit and non-profit entities are funded to demonstrate model service delivery projects for substance abusing pregnant women. The program also funds projects that address the needs of infants and young children who were exposed to drugs in-utero. The projects provide prevention, education, and treatment services offered in community, inpatient, outpatient and residential settings.	OSAP MCHB	32.5 m	$45.6 m	$52.6 m
Residential Drug Prevention and Treatment Projects for Substance Abusing Women and Their Children	These demonstration grants were first awarded in September, 1992 to support the development of comprehensive residential programs specifically designed for substance-abusing women and their children. The facilities in which the mothers and children live will provide comprehensive services including community prevention, treatment and aftercare services. Funding for this program is provided by the Special Forfeiture Fund of the ONDCP.	OSAP	-	-	$10.1 m
Studies on Drug-Exposed Infants	The Office of Inspector General has conducted four studies on drug-exposed infants. They are as follows: "Crack Babies," "Crack Babies: Selected Model Practices," "Boarder Babies," and Prenatal Substance Exposure: State Child Welfare Laws and Procedures."	OIG	*	*	*
Study on the Impact on Service Delivery of Families with Substance Abuse Problems	In FY91, ACF began a study of the short and long-term impact of families with substance abuse problems on service delivery within ACF programs, including Head Start, youth services and child welfare services.	ACF	-	*	*
Temporary Child Care for Children with Disabilities and Crisis Nurseries Program	This program provides services to abused and neglected infants, many of whom are from drug involved families. In seven of the nine crisis nurseries projects funded in FY91, children in drug-abusing homes were specifically referenced among those served.	ACF	$8.3 m	$11.1 m	$11.1 m

* Funding information not available.

The funding streams that have been identified through our investigation provide a broad sweep of likely sources that may be used to finance services for drug-exposed infants and their families. Most agencies listed within the compendium are merely potential sources, since they fund discreet components of the CHPR model. Only a handful of research demonstration programs are explicitly designated to fund comprehensive service delivery for drug-exposed infants and their families. They include: 1. CSAT Pregnant and Postpartum Women with Children, 2. NIDA Perinatal 20, and 3. HCFA Improving Access to Care programs. Research demonstration projects can be very valuable since so little is known about what is effective in treating addicted pregnant women with children. The information that can be gained from research demonstration projects is necessary if we are to understand how to prevent prenatal drug exposure.

The disadvantage of demonstration project money is the limitation on time and renewal. Non-renewable demonstration projects are usually limited to 3 to 5 years of funding. Although it is theoretically possible to extend promising demonstration projects through block grant money or Medicaid, there is no strategy or government policy to facilitate this transition. To illustrate how funding works, we will describe the principal sources of funding in more detail.

SAMHSA

The Substance Abuse and Mental Health Services Administration

As a result of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act of 1992 (PL 102-321), SAMSHA was created to replace ADAMHA. The purpose of this realignment, was to "fully develop the Federal government's ability to target effectively substance abuse and mental health services to the people most in need, and to translate research in these areas more effectively and more rapidly into the general health care system." SAMSHA is focused on treatment and services for people who are mentally ill or chemically dependent. SAMHSA is comprised of three agencies: The Center for Substance Abuse Treatment (CSAT) (formerly the Office of Treatment Improvement), the Center for Substance Abuse Prevention (CSAP) (formerly the Office of Substance Abuse Prevention), and a newly created Center for Mental Health Services (CMHS).

The 1992 Reorganization law established two major sources within SAMHSA for funding services and research related to drug-exposed babies and their families: The Block Grant for the Prevention and Treatment of Substance Abuse and the Pregnant and Postpartum Women and Their Infants Program (PPWI). Both programs are administered by CSAT. In addition, the law created an Advisory Committee for Women's Services to identify needs for services and coordination and to assure that the unique needs of minority women are addressed.

Block Grant For The Prevention And Treatment Of Substance Abuse

Up until the enactment of the Reorganization bill, a major federal/state source of funding

for on-going support for drug-exposed babies and their families has been the alcohol, drug and mental health block grant program within ADAMHA. Although funding under this program increased 500 percent -- from $24.4 million to $119.3 million -- between 1988 and 1990 and contained a 10% set-aside for substance abuse treatment of pregnant women with dependent children, there is no systematic way of surveying states on how the 10% set-aside has been utilized. The GAO (1991) reviewed annual reports of 50 states and conducted site visits in seven states but was unable to determine if 29 states had used the funds for the federally-specified purpose. Two of the site-visit states did not use the set-aside funds for pregnant women. The GAO concluded that states are not held accountable for how the set-aside money is used.

As a result of the 1992 Reorganization law, the ADAMHA block grant was split into two grants: one for mental health services and one for substance abuse treatment and prevention services. The formula under which each State's block grant allotment is determined was also modified. No state will receive less than its FY 1991 allocation through 1994. Funds authorized for the substance abuse block grant in FY 1993 are to be used to implement the Institute of Medicine (1990) core plan for comprehensive treatment for pregnant women and IV drug users: Reduction of waiting lists, improvement of treatment quality, and dedicated efforts to treat expectant mothers and provide onsite childcare for other parents of young children.

The new substance abuse block grant program is authorized at $1.5 billion dollars for FY92, for planning, carrying out and evaluating activities to prevent and treat substance abuse. Categorical breakdown of this appropriation includes: 35% for alcohol services, 35% for drug abuse services provisions, and 20% for the prevention set-aside. In addition, the new formula

modifies the previous 10% set-aside for women to 5% targeted specifically to pregnant women and women with dependent children. Another 5% increase will occur in FY94 to increase availability of services relative to the previous year. The remaining 5% of the block grant formula is for SAMHSA for technical assistance, data collection, program evaluations and for the new national prevention data base. A portion of this set-aside may also be used to assist State prevention services efforts. The block grant is one of the most substantial funding sources for pregnant substance abusing women and their children. However, since each state has a different format for reporting their utilization of these funds, it is not possible to determine how the set-asides are being used (Government Information Services, 1992). See Appendix F for more information on the Substance Abuse Block Grant program.

PREGNANT AND POSTPARTUM WOMEN AND THEIR INFANTS PROGRAM (PPWI)

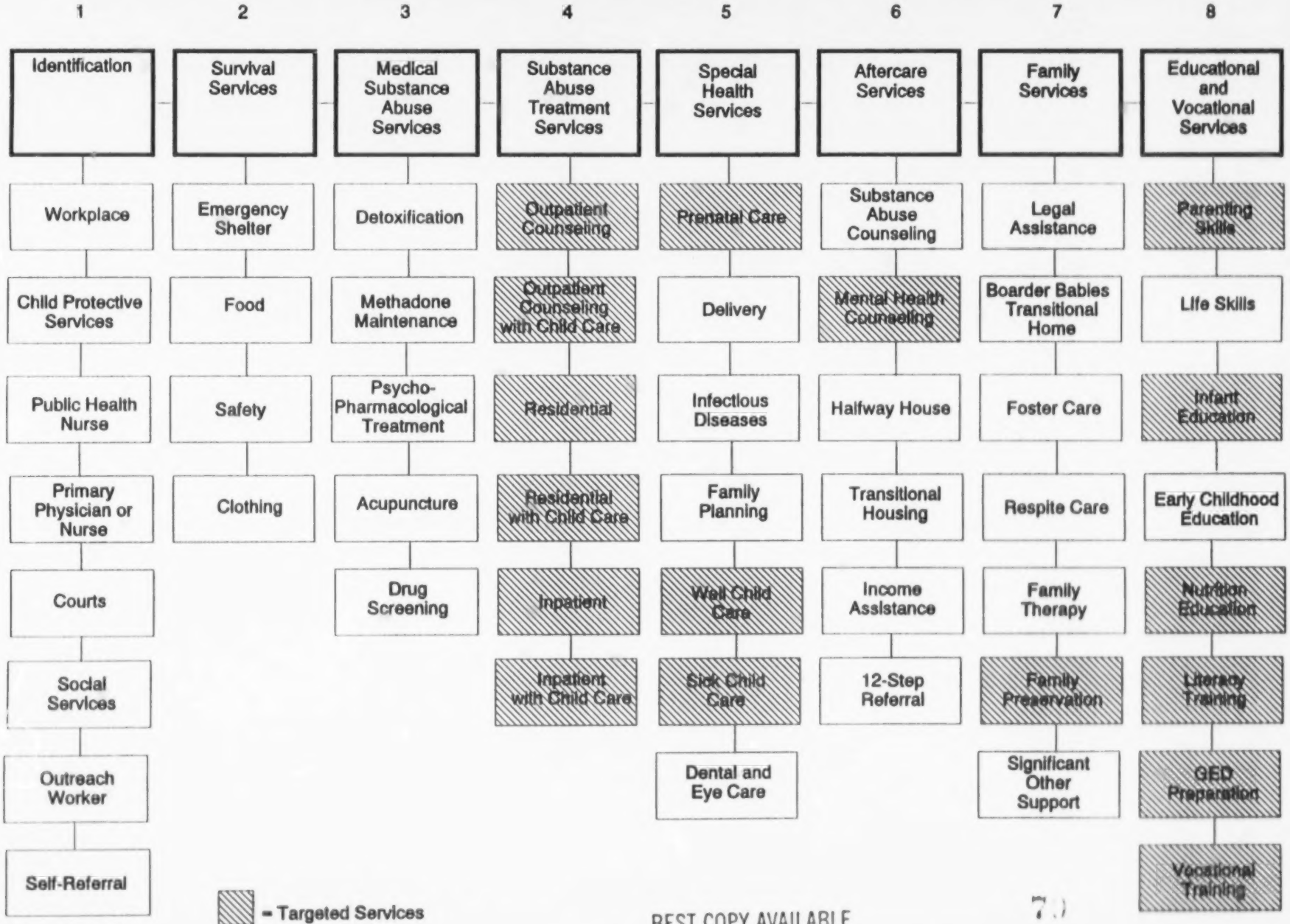
Another program administered by CSAT under SAMHSA is the Pregnant and Postpartum Women and Their Infants (PPWI) federal demonstration project. This program targets the population of potential or current substance abusing pregnant or postpartum women and their infants, with low income women as priority. The PPWI program is spilt into two grant programs, one funds residential treatment services for pregnant and postpartum women and their minor children and the other funds outpatient treatment programs for pregnant and postpartum women. The two programs are authorized at $100 million for FY 93, with priority funding of $80 million for the residential grant program. Approximately $6 million dollars was available for 20-25 model projects in FY92.

○ *Residential Treatment Programs for Pregnant and Postpartum Women:* CSAT will provide 3-5 year grants to public or non-profit groups to provide pregnant and postpartum women with treatment for substance abuse. To qualify for a PPWI grant, treatment programs must meet the following requirements: 1. the program must be operated in location accessible to low income pregnant/postpartum women, 2. services must be language and culturally sensitive, 3. applicant will provide continuing education for treatment staff, and 4. charges for services must be provided on a sliding scale. CSAT specifies that grants must be equitably allocated among geographical regions.

○ *Outpatient Treatment for Pregnant and PostPartum Women*: Grant program outpatient treatment of pregnant and postpartum women and infants. This program included treatment and prevention services, including outpatient treatment for children with conditions arising from maternal substance abuse. Figure 7 displays the services within the CHPR Comprehensive Model funded by the PPWI program. Appendices G and H contain further description of the PPWI program with examples of current grantees.

Figure 7

PREGNANT AND POSTPARTUM WOMEN AND THEIR INFANTS DEMONSTRATION PROGRAM



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NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

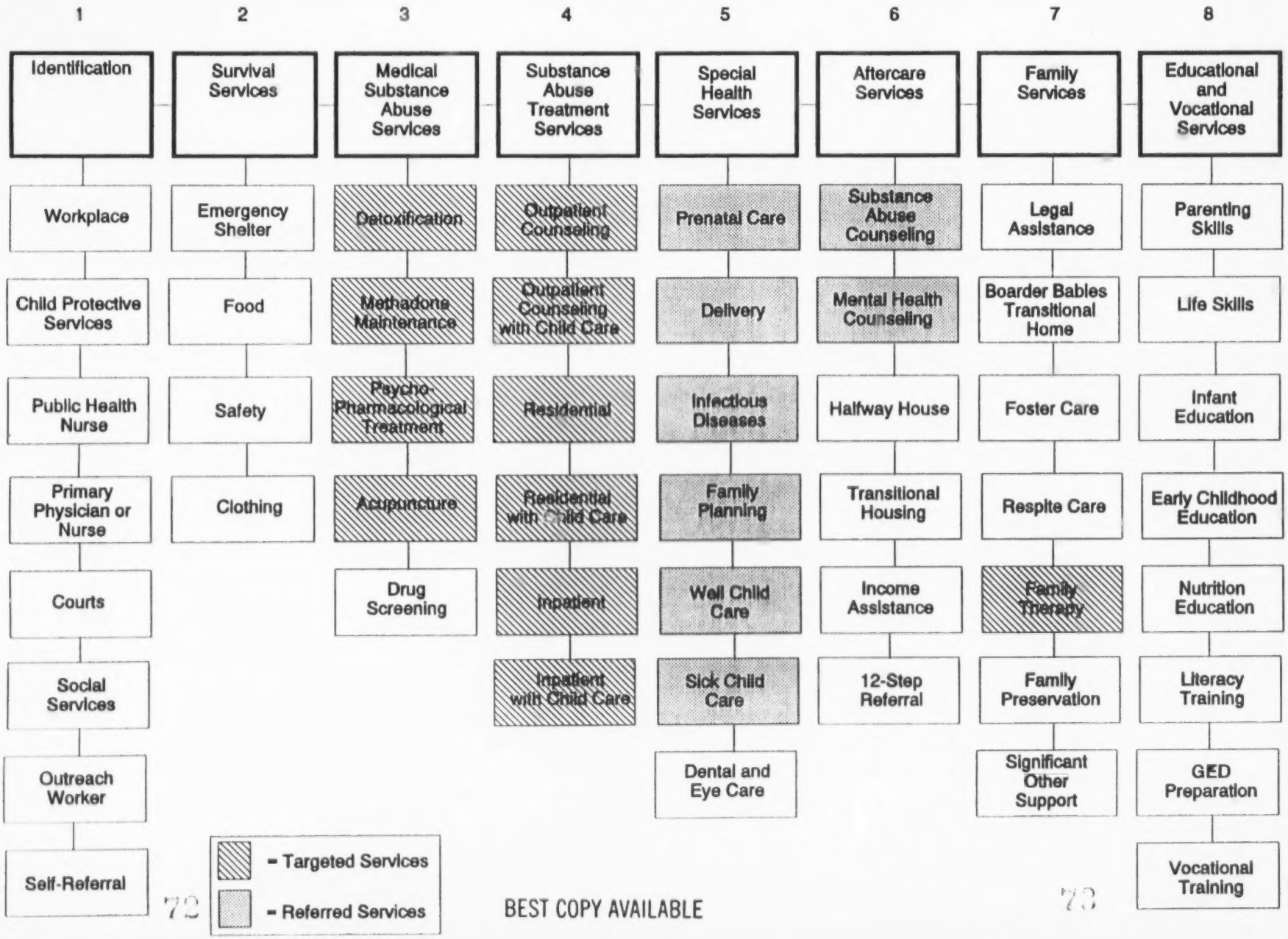
As part of the 1992 reorganization law, the National Institute on Drug Abuse (NIDA) was transferred to the National Institutes of Health (NIH). Since NIH does not support demonstration projects, this action dismantled the NIDA research demonstration program, including one of the most important research programs concerned with treatment of addicted women and their children. Under NIH, NIDA will be limited to funding the research evaluation portion of a research demonstration project for addicted women and their children.

NIDA Treatment Research Demonstration Program

The "Perinatal 20" Treatment Research Demonstration Grant program under NIDA was developed to scientifically evaluate the effectiveness of each of twenty-one comprehensive therapeutic programs designed for drug abusing women of childbearing age and their offspring. Evaluation included program characteristics such as: facility and physical environment, therapeutic approaches, supportive approaches, and time in treatment and program management as they influence the following outcomes: Service utilization, use of alcohol and drugs, employment status, criminal behavior, family relationships and parenting skills. Most programs combine detoxification and long term drug treatment with a full range of medical care. In addition, they integrate and coordinate linkages with a wide and varied range of support services. The total program is funded for $17 million. Individual grants ranged between $250,000 to $2 million. Figure 8 displays the services targeted by the NIDA Perinatal 20 program. Appendix I contains a list of the NIDA Perinatal 20 grantees and a discussion of the project.

Figure 8

NIDA 20



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ADMINISTRATION FOR CHILDREN AND FAMILIES

Foster Care

According to the U.S. House of Representatives Committee on Ways and Means (1992), the proportion of children in foster care has escalated from 3.9 per 1000 in 1962 to 5.9 per 1000 in 1990. State foster care admissions were almost equal to the discharges until 1986 when caseloads in many states multiplied as new admissions rose and discharges fell. The greatest increases occurred in California, Illinois and New York. It is speculated that a large portion of this increase resulted from the introduction of crack cocaine in the mid-1980s. According to the Child Welfare League of America (CWLA) 88% of the child protective service workers surveyed in 1992 reported they were seeing a higher percentage of cases involving drug and alcohol abuse than they did 5 years earlier.

The most significant impact of crack cocaine on the child welfare system is the influx of infants entering foster care as a result of prenatal drug usage, drug toxicity at birth, and abandonment at birth (boarder babies). Drug exposed infants often enter substitute care shortly after birth as a result of a diagnosed failure to thrive, or parental abuse and neglect. From 1985 to 1988, New York foster care infant admissions for children less than 1 year old increased by 89 percent. In Illinois, admissions rose 58 percent for the same period. This phenomenon has stretched child welfare systems beyond their limits.

The adoption of P.L.96-272 in 1980 was designed to encourage child welfare agencies to shift their focus from the safety needs of the individual child to the broader needs of the child within the family. This change was based on the supposition that children develop best in their

own families and that most families are worth saving. The law mandates agencies to make reasonable efforts to prevent a child's placement in foster care and to reunite family members as soon as possible if foster care placement is unavoidable. While the principles behind P.L.96-272 are sound, most communities do not have the resources to comply with the legislation as it was intended.

McCullough (1991) has identified obstacles that impede the ability of the child welfare system to care for drug exposed children and their families. They are: 1. Lack of sufficient numbers of workers to handle the case loads. For example, in the District of Columbia the average caseworker handles 61 families. Some caseloads are as high as 117 families. 2. Lack of training and knowledge to deal with alcohol and drug problems. 3. Lack of courts and judges who are capable of making sound decisions regarding drug addicted parents with children. 4. Lack of adequate resources to meet the requirements of P.L. 96-272, including accessible treatment for uninsured individuals. 5. Lack of coordination of existing services. 6. Lack of available alternatives when a decision is made to remove a child. 7. Lack of safety and presence of violence in neighborhoods where caseworkers must work. To this list, we add the problem of burnout among all welfare workers who serve this population.

Family Preservation

The dramatic increase in foster care rolls has generated new interest in ways to preserve families and prevent the need for foster care. The first of the family preservation initiatives was Homebuilders in Washington state. Since 1974, Homebuilders has served over 5000 children from the child welfare, mental health, special education and juvenile justice systems. A variation

of the model has been replicated in more than 30 states.

Table 1 compares the traditional child welfare foster care service model with the family preservation model.

TABLE 1: SERVICE DELIVERY SHIFTS

TRADITIONAL	FAMILY PRESERVATION
office based	in-home
long-term, open-ended	short-term, goal oriented
waiting list, office hours	immediate response, 24 hour
weekly or less	frequent, often daily
large caseload	small caseload
talk therapy	skill building, concrete help
focus deficits	focus on strengths
worker-selected solutions	family-selected solutions
focus on individual	focus on family
program determines services	family determines services
bureaucracy driven	outcome driven

In the state of Maryland, the annual costs per child in the child welfare system averaged $14,400 in 1990. A juvenile justice placement in New York costs approximately $70,000. A typical family preservation service costs between $2000 and $3000 per family.

The Social Security Act contains four primary sources of funds available to states for child welfare, foster care and adoption services. These programs are administered under the Administration for Children and Families (ACF) and include Title IV-B child welfare services program assistance, Title IV-E foster care , Title IV-E adoption assistance and Title XX social

services block grant. The adoption assistance program aids states with adoption of AFDC or SSI eligible children with special needs such as age, sibling groups, mental or physical handicaps, or ethnic background. There are also several private sources of funding for this service. Appendix J contains a discussion of the family preservation services and the various sources for support.

Administration for Children and Families: Head Start

The Head Start Program operates on the principle that the child's development is best addressed by strengthening the family's capacity to be the primary nurturer and educator of its children. Head Start programs have found that families under severe stress as a result of problems, such as illiteracy and dependence on alcohol and drugs, are unable to take full advantage of the opportunities offered by Head Start and often are unable to sustain their own and their children's participation in the program. The Head Start Program has begun to adapt its program to the needs of these families by training their grantees to identify parental substance abuse and intervene appropriately.

Since it's implementation in 1965, Head Start has served about 12.5 million children from low-income families in all 50 states and territories. The program's goal is to build confidence and improve the health of low income children, to enable them to be on an equal basis with their more fortunate classmates. Head Start provides education, health improvement services, nutrition and social services to the target population. Head Start programs are primarily for children from age 3 up to the age when the child enters the school system, but may

include some younger children. Appropriations have increased from $1.4 billion in FY90 and $2 billion in FY91 to the current FY92 appropriation at $2.2 billion, which serves 1,346 programs and 622,000 children. Figure 9 displays the services within the CHPR Comprehensive Model that can be funded the Administration for Children and Families, which includes Foster Care, Headstart and Family Preservation. Appendix K contains a description of the Headstart program.

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Medicaid

Medicaid is the most stable and comprehensive source of funding many of the services needed by drug-exposed infants and their families. Although Medicaid was not designed to fund alcohol and drug treatment, an increasing number of states are using it for that purpose. The National Drug and Alcoholism Treatment Unit Survey (NDATUS), reports that Medicaid reimbursements for substance abuse treatment doubled between 1982 and 1987. However, obtaining Medicaid dollars for substance abuse treatment can be a complicated process. The individual, the service and the provider institution are all required to meet a complex set of qualifying criteria. States participate in the Medicaid program on an optional basis and administer it within broad federal requirements and guidelines which allow considerable discretion in determining eligibility, covered benefits and provider payment mechanisms. Therefore, very little uniformity exists from one state to the next.

Medicaid Eligibility for Pregnant Women and their Children

Since eligibility requirements for pregnant women are less restrictive with the highest income eligibility limits, states can provide pregnant women with an enhanced package of services without the burden of funding those services for all Medicaid beneficiaries. At a minimum, states must cover individuals with a net income less than or equal to 133% of poverty or 33% above the poverty line ($14,463 for a family of 4 in 1992). Asset tests (ownership of

durable goods), normally required for Medicaid eligibility, have been eliminated for pregnant women in 46 states. Coverage extends throughout a woman's pregnancy and the last day of the month in which 60th postpartum day occurs. The maximum level of Medicaid coverage can be limitless.

Eligibility rules for children vary depending on the age of the child. Newborns are automatically eligible if their mother was eligible at the time of their birth and remain eligible until their first birthday under income standards applicable to pregnant women. Children ages 1 through 19 are eligible if their families' income meets criteria. EPSDT (Early Periodic Screening, Diagnosis and Treatment) is another benefit package for anyone less than 21 years of age who is eligible. A list of the services covered under EPSDT are contained in Appendix L.

Medicaid Eligibility for Institutions

Medicaid will cover almost all hospital based services. However, most substance abuse treatment services are provided within nonhospital (freestanding) residential treatment institutions which are the most difficult to cover under Medicaid due to the IMD (Institution for Mental Disease) Exclusion (Gates, 1992). The IMD Exclusion is a provision of the Medicaid Statute that prohibits coverage for anyone under 65 who is an inpatient in an institution for mental diseases. By finding a residential substance abuse treatment center to be an IMD, any person under the age of 65 residing in that program is excluded from Medicaid coverage, not just for substance abuse treatment but for any Medicaid covered service (Gates, 1992).

Medicaid Eligibility for Services

Medicaid is designed to finance services that typically fit the medical model. Although most states cover short term hospital treatment for a 3-6 day inpatient detoxification stay and a limited number of out-patient counseling visits, there are very few long term substance abuse treatment options for Medicaid patients. The result is a cycle of relapse and return to detox. Access to long term care is critical if treatment for addicted pregnant women is to be successful. David Gates (1992), an expert in Medicaid legislation, has provided suggestions on how services recommended in the OTI Criteria for Comprehensive Treatment can be covered under Medicaid. The complete OTI Criteria for Comprehensive treatment has been integrated within the CHPR Model (see Appendix M).

- *Intake and Assessment:* Consists of medical exam, drug use history, a psychosocial evaluation, and when warranted, a psychiatric evaluation. Medicaid covers medical exams, and psychiatric evaluations but at a low reimbursement rate so these evaluations are usually done by community mental health centers. Psychosocial evaluations can be covered under Medicaid if performed by a licensed psychologist or other treatment professional licensed under State law to perform such evaluations. If the psychosocial evaluation is performed by an unlicensed personnel, it can be covered under Medicaid as an component of case management. Drug history assessment can fall under case management, or can also be covered as a component of a medical exam or a psychiatric evaluation. Medical screening can be covered for patients under 21 through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Identification of individuals requiring these assessment services can be accomplished through any of the components of column 1 of the CHPR Comprehensive Model.

- *On Site Provision of Preventive and Primary Medical Care:* Achieved by combining a

Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) with an alcohol and other drug dependency treatment program. FQHCs can be community health centers, migrant health centers, health care for homeless, rural health centers, and outpatient health programs by tribal organizations. On site preventive and primary medical care can also be covered when provided by outpatient hospital clinics or by freestanding medical clinics. Also, individual doctors or group practices can treat the patient and bill Medicaid by this approach, but many doctors will not accept Medicaid. These services are represented in columns 3, 4, and 5 of the CHPR Comprehensive Model.

- *Testing for Communicable Diseases and Urine Screening:* Tests that are ordered by a physician at intake and during treatment for communicable diseases and urinalysis on a weekly basis for treatment compliance can be covered under Medicaid as any laboratory services. These services are covered in columns 3 and 5 of the CHPR Comprehensive Model.

- *Pharmacotherapeutic Intervention:* Pharmacotherapeutic intervention can be covered by Medicaid under several categories: Physicians services for the prescribing of the medication, prescribed drugs for the drugs itself and the dispensing of the drug and the laboratory services for serum-level tests or urinalysis. Methadone maintenance or pharmacological interventions for anxiety or depressive disorders may also be covered. Recently, Oregon has obtained federal approval to offer acupuncture as a Medicaid covered service for substance abusers. Acupuncture is an effective treatment for cocaine craving. These services are covered in column 3 of the CHPR Comprehensive Model.

- *Counseling of HIV-Positive Persons:* Counseling of HIV-Positive persons is not clearly covered by Medicaid; coverage depends on who is doing the counseling and on the type of

counseling they are doing. Counseling that is usually covered includes counseling by a physician, an FQHC, RHC, medical clinic or other licensed practitioner when such counseling is within the scope of state law. Counseling for emotional problems can be provided by a psychiatrist as a physician's service, or by a psychologist or mental health professional to the extent authorized by State law. Counseling not already listed might fall under the "rehab option," if recommended by a physician or other licensed practitioner. Counseling for social problems is problematic since coverage by Medicaid is limited to "medical or remedial services." This service is included in column 6 of the CHPR comprehensive model.

- *Counseling for Substance Abusers and Their Families:* Inpatient substance abuse counseling, psychological counseling, psychiatric counseling, and family or collateral counseling are all covered by Medicaid unless the inpatient treatment program is considered an IMD and falls under the IMD exclusion. At a hospital, these services must be categorized as an inpatient or outpatient hospital service. If provided by a freestanding clinic on an outpatient basis, they are covered as a clinic service. They can be covered if provided by a psychologist or other licensed mental health practitioner under the category of medical or remedial care, or if it is in a community health care center under the clinic option or by a physician agreeable to reimbursement rates. Family or collateral counseling can be more problematic, since Medicaid only covers the eligible persons. For those who are eligible counseling must be "necessary," and directly involve the substance abusing person. These services are included in columns 4 and 7 of the CHPR Comprehensive Model.

- *Life Skills Counseling and Training:* Practical life skills counseling and training can be covered as a rehab service if it is designed and billed as a component of the alcohol and other

drug dependency counseling. These services are included in column 8 of the CHPR Comprehensive Model.

○ *Vocational and Educational Training:* Although vocational and educational training are vital to substance abusing persons, they are not covered under Medicaid. Assessments and referrals for vocational and educational services can be covered under Medicaid as a component of case management.

○ *Peer Support Groups:* According to HCFA, peer support groups do not constitute "medical or remedial services" for Medicaid purposes.

○ *Aftercare Services:* Aftercare services may or may not be covered by Medicaid. Outpatient counseling as aftercare following residential treatment can clearly be covered, but support group activities may not be covered. These services are covered within column 6 of the CHPR Comprehensive Model.

There is a wide discrepancy between the potential of Medicaid as a source of funding for drug-exposed children and their families and the ability to access those funds. Consequently, a total of $6 million has been awarded by HCFA to administer 5 demonstration projects to improve access to care for pregnant substance abusers and their children. Appendix M contains a description of the demonstration projects for improving access to care for pregnant substance abusers and further discussion on the barriers to obtaining Medicaid reimbursement for this population.

Figures 10 and 11 display the service components of the CHPR Comprehensive Model that can be funded for women and children under Medicaid.

Figure 10

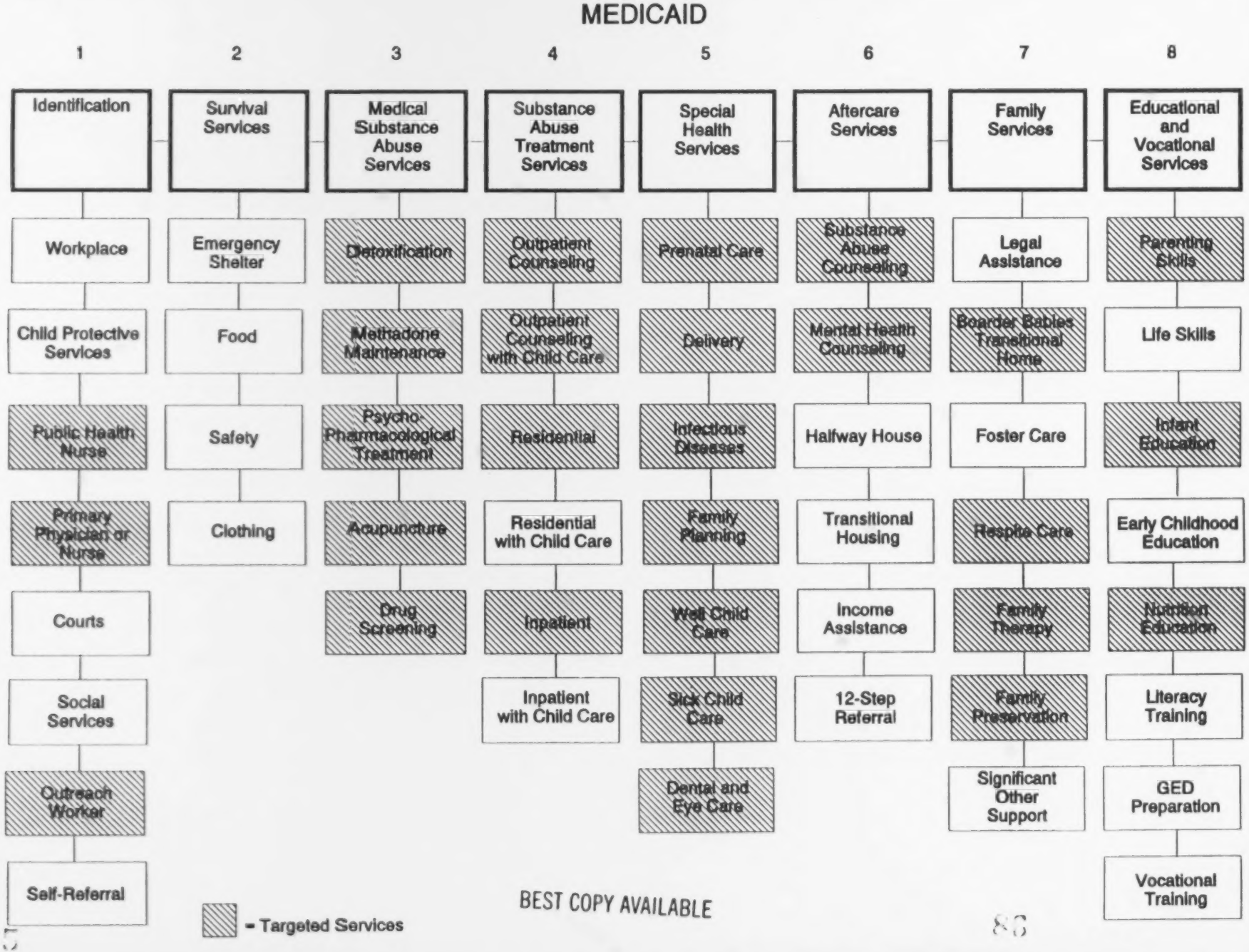

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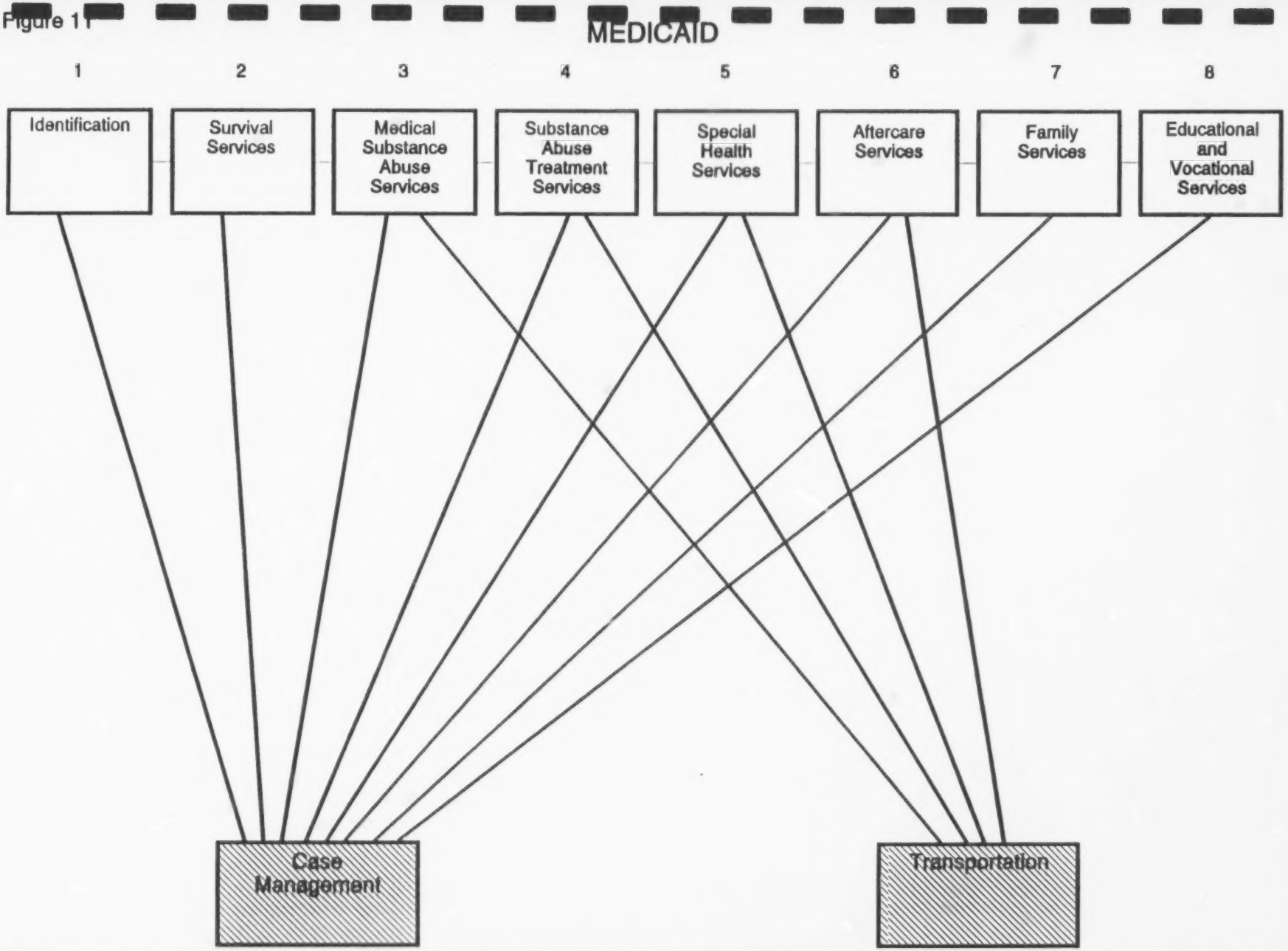
Figure 11



Transportation and Case Management services are critical components of the service delivery model and allow the drug-exposed infant and their families to make the transition from one stage to the next.

▨ = Targeted Services

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CASE STUDIES

Funding Comprehensive Care For Drug-Exposed Babies and Families

The task of identifying the myriad of funding sources for drug-exposed infants and their families required an inordinate amount of time and persistence. We were constantly impressed with the effort it took to obtain information about funding sources and funding availability. We found funding for this population to be fragmented, time-limited and difficult to access. We could only speculate on how difficult it must be for treatment providers to finance their programs.

Funding comprehensive programs requires a sophisticated level of both substance abuse treatment and fiscal management. No single funding source can support all components of a comprehensive treatment program for drug-exposed children and their families. Indeed, it often takes several sources to fund one component. For example, block grant funds from the Maternal and Child Health Bureau may provide partial funding for community outreach and identification. Medicaid might pay for detoxification, out-patient counseling services or prescription drugs. State revenues or Alcohol and Drug Abuse block grant may support drug-free housing. The Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse Treatment (CSAT) might support a demonstration project for 3 to 5 years for the initial development or expansion of a comprehensive program but will not renew the grant even if the project is very successful and not fundable under another source. NIDA may support the scientific evaluation of an innovative demonstration project which is designed with scientific rigor, but may not support delivery of services.

The instability and short duration of most federal and private grants requires administrators of treatment programs for pregnant women to spend much of their time securing funding, negotiating a plethora of complex bureaucracies and planning from year to year. The limited nature of most funding mechanisms creates serious barriers to promoting long-term program development that fully addresses the needs of pregnant women substance abusers and their families.

We wanted to know who successfully accessed government and private funding and how they used it. Since there are a limited number of research demonstration projects, we wanted to know what could be accomplished with such grants. We began by seeking exemplary programs that successfully support a comprehensive model of care. We found many creative examples of treatment for addicted pregnant women and their children and were impressed with the valuable findings that were being generated by the research demonstration projects. Unfortunately, we are unable to describe all of the programs in this report. Our case studies were selected to illustrate specific aspects of funding that cannot be appreciated without particular examples.

The benefit of funds is only part of the solution. Some communities have difficulty utilizing available money because of deficiencies within their own infrastructure. Recently, the Washington Post reported a three-month District of Columbia study conducted by a team of Federal Public Health Service analysts. According to the Post, 1.) the District's Alcohol and Drug Abuse Services Administration failed to use $5 million in federal money designated for drug treatment within the city; 2.) no billings for Medicaid reimbursements had occurred in almost six months and only one person was trained to do the paper work; 3.) client-to-counselor ratios were 50 to 1; 4.) fewer than 10% of the counselors were certified; and 5.) many

employees involved in awarding city contracts do not have the skills of the background to perform their job. Washington, D.C. is estimated to have 128,000 residents, 20% of the population, in need of treatment and to have one of the highest infant mortality rates in the country (Goldstein, 1992).

To illustrate how comprehensive service delivery can be funded, we have selected two exemplary models: Operation PAR (Parental Awareness and Responsibility), St. Petersburg, Florida, and CSTAR (Comprehensive Substance Treatment and Rehabilitation Program), State of Missouri. Operation PAR is a not-for-profit therapeutic community, which provides long-term substance abuse treatment for severely impaired individuals including pregnant mothers with children. CSTAR is a State Alcohol and Drug Administration approach to community based long-term substance abuse treatment for all substance-dependent residents of Missouri including pregnant women and their children. The funding of both programs is unique to the communities they serve. We present them not as examples of treatment that should be replicated throughout the country, since that may not be feasible, but rather as examples of creative use of the fiscal resources available to them.

OPERATION PAR, INC.

Parental Awareness and Responsibility

St. Petersburg, Florida

Operation PAR was founded in 1970 by the State Attorney, Sheriff and County Commissioner for assisting Pinellas County, Florida, residents who had problems resulting from alcohol and drug abuse. It is the largest, and most comprehensive, non-profit system of substance abuse treatment, prevention and training services in the southeastern United States. It maintains an annual budget of 12 million dollars and employs 3 grant writers and 3 accountants to write and manage the 45 to 50 contracts that fund the various programs. Several programs are designed specifically for addicted mothers and their children.

Operation PAR offers a continuum of services for substance abusing or addicted pregnant and post-partum women. Services include inter-agency linkages and referrals, case management, outpatient, individual and group counseling, intensive day treatment, and short and long-term residential treatment for women with therapeutic day care and developmental services for their children. Referrals come from hospitals, clinics, physicians, child protective services, foster care, the States Attorney's Office, the Department of Corrections and other community agencies. A description of the programs that serve addicted pregnant women and their children is contained in Appendix N. Figure 12 displays the components of the CHPR Comprehensive Model that are provided through the Operation PAR program. Figure 13 displays the funding sources for residential treatment for pregnant women with children within Operation PAR (PAR Village). Figure 14 displays Operations PAR's services reimbursed by Medicaid. Appendix N

lists the sources of revenue that support the Operation PAR programs that serve addicted pregnant women and their children.

Figure 12

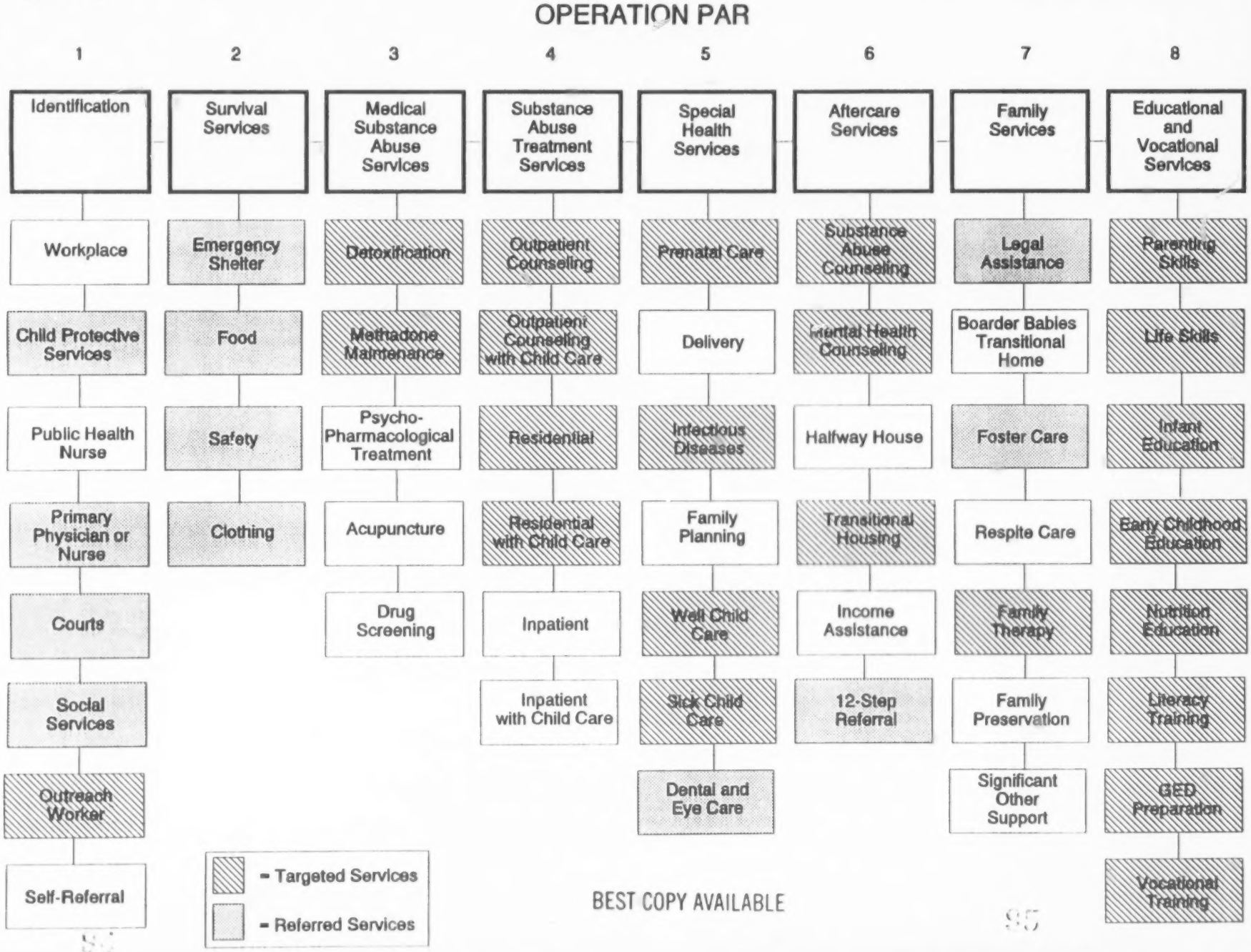

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Figure 13

OPERATION PAR

SOURCES OF FUNDING FOR PAR VILLAGE

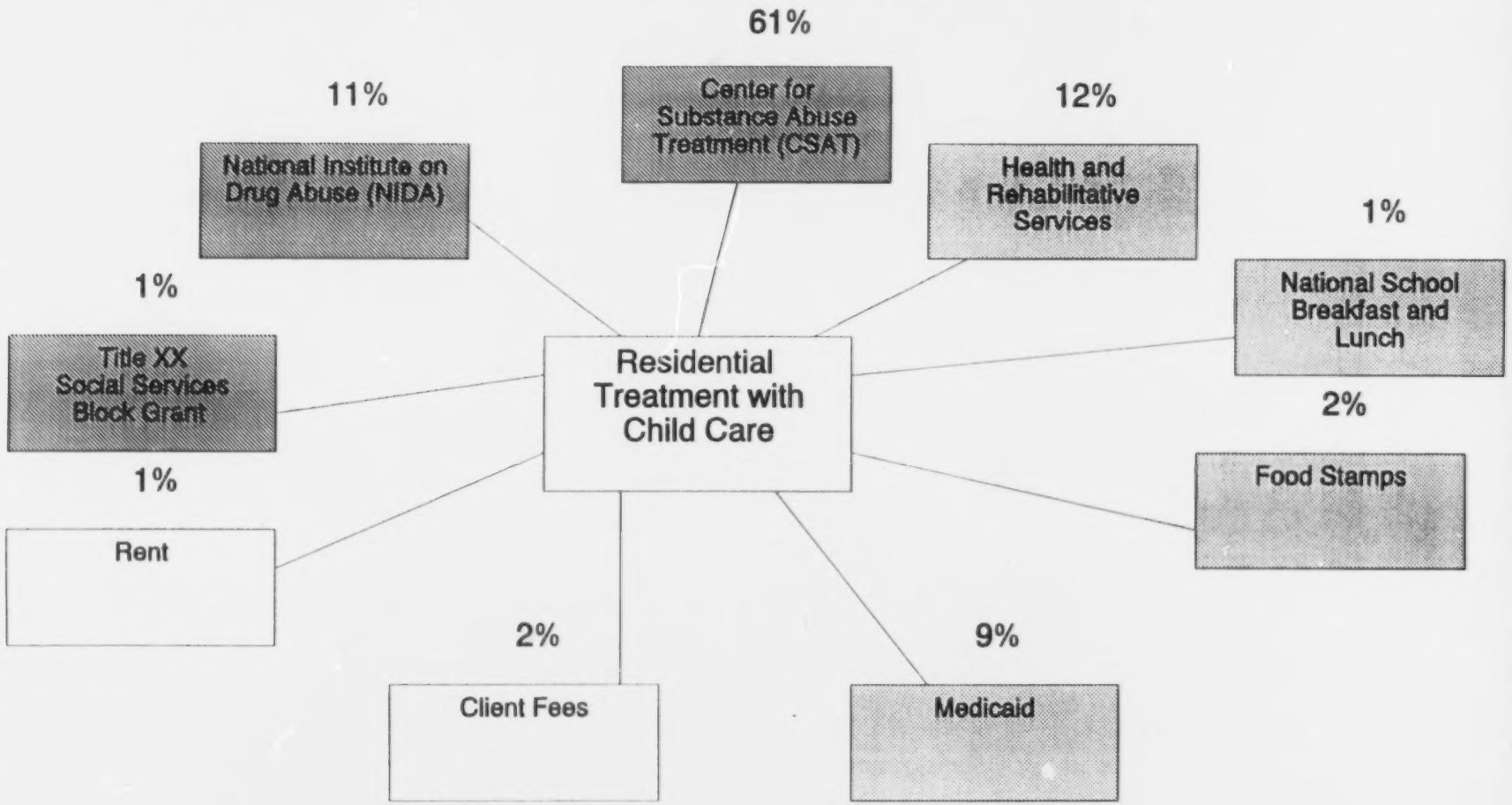

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Figure 14

OPERATION PAR

MEDICAID

The CSTAR PROGRAM

Comprehensive Substance Treatment and Rehabilitation Program

State of Missouri

CSTAR (Comprehensive Substance Treatment and Rehabilitation Program), one of the most innovative state substance abuse programs in the country, is designed to provide holistic treatment and support to all individuals and families with a substance abuse problem in the State of Missouri. It began June, 1991, with 33 CSTAR programs across the state. Built on a community-based model, CSTAR offers a wide range of individualized services organized according to three levels of care: The Community-Based Primary Treatment Level, Community-Based Rehabilitation Level, and the Supported Recovery Level. CSTAR programs are located within 60 miles of each other, and serve both rural and urban communities. All programs are culturally sensitive, and some are specialized for pregnant and postpartum women and their children.

A shift away from a "provider driven to client driven" treatment philosophy within the Missouri Department of Mental Health permitted services to be restructured according to eligibility criteria for Medicaid reimbursement. Missouri's Medicaid plan uses the rehabilitation option so that out-patient services can be delivered by a variety of different professionals and paraprofessionals in settings such as a clients' home.

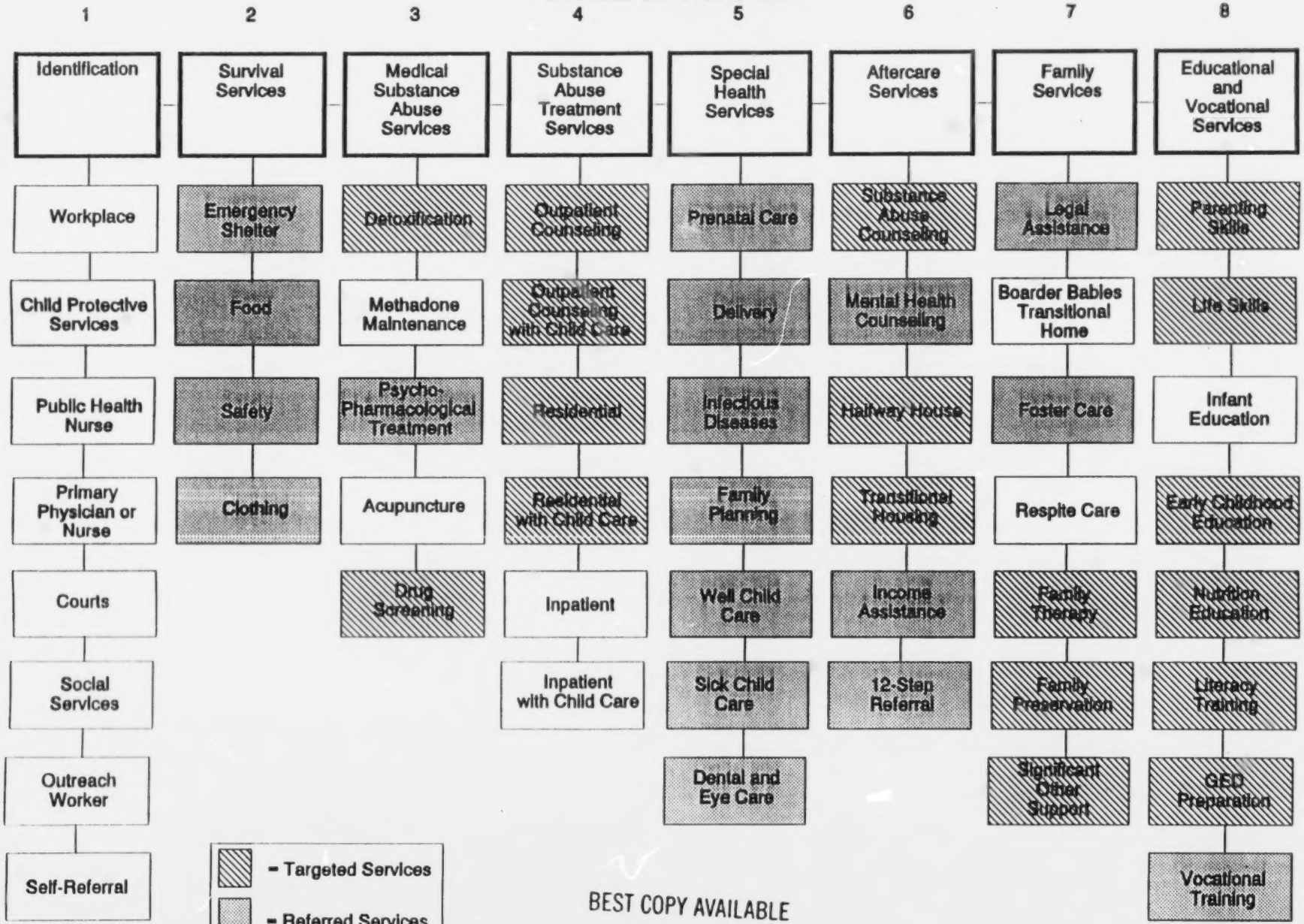
The Missouri Division of Alcohol and Drug Abuse (ADA) maximized the potential for Medicaid reimbursement by requiring residential facilities for women and children to provide room, board and overnight nursing supervision in establishments with 16 beds or less, thereby

overcoming the IMD exclusion barrier (see page 56 for explanation of IMD exclusion). They also required providers to be eligible for Medicaid reimbursement in order to be certified as part of the CSTAR network of services.

As a result of major restructuring of services and a seamless system of electronic processing which allows all CSTAR providers to transmit authorization plans, demographic data, and invoices electronically to ADA, most services in CSTAR programs can be reimbursed efficiently through Medicaid funds or other sources. Clients and services not eligible for Medicaid are automatically identified and directed through the unique fiscal and billing system to the proper funding source. For example child care, housing rent assistance and services for clients ineligible for Medicaid are reimbursed most often through substance abuse block grant money by a Purchase of Service (POS) from the State Department of Mental Health. The following is contained in Appendix O: a description of the CSTAR programs for women and children, the CSTAR authorization and payment process and fiscal report for one year. The POS column indicated the expenses reimbursed by funds other than Medicaid. Figure 15 displays the provided services and the referred services contained within the CSTAR program. Figure 16 displays the CSTAR's services reimbursed by Medicaid.

Figure 15

COMPREHENSIVE SUBSTANCE TREATMENT AND REHABILITATION PROGRAM (CSTAR)
STATE OF MISSOURI



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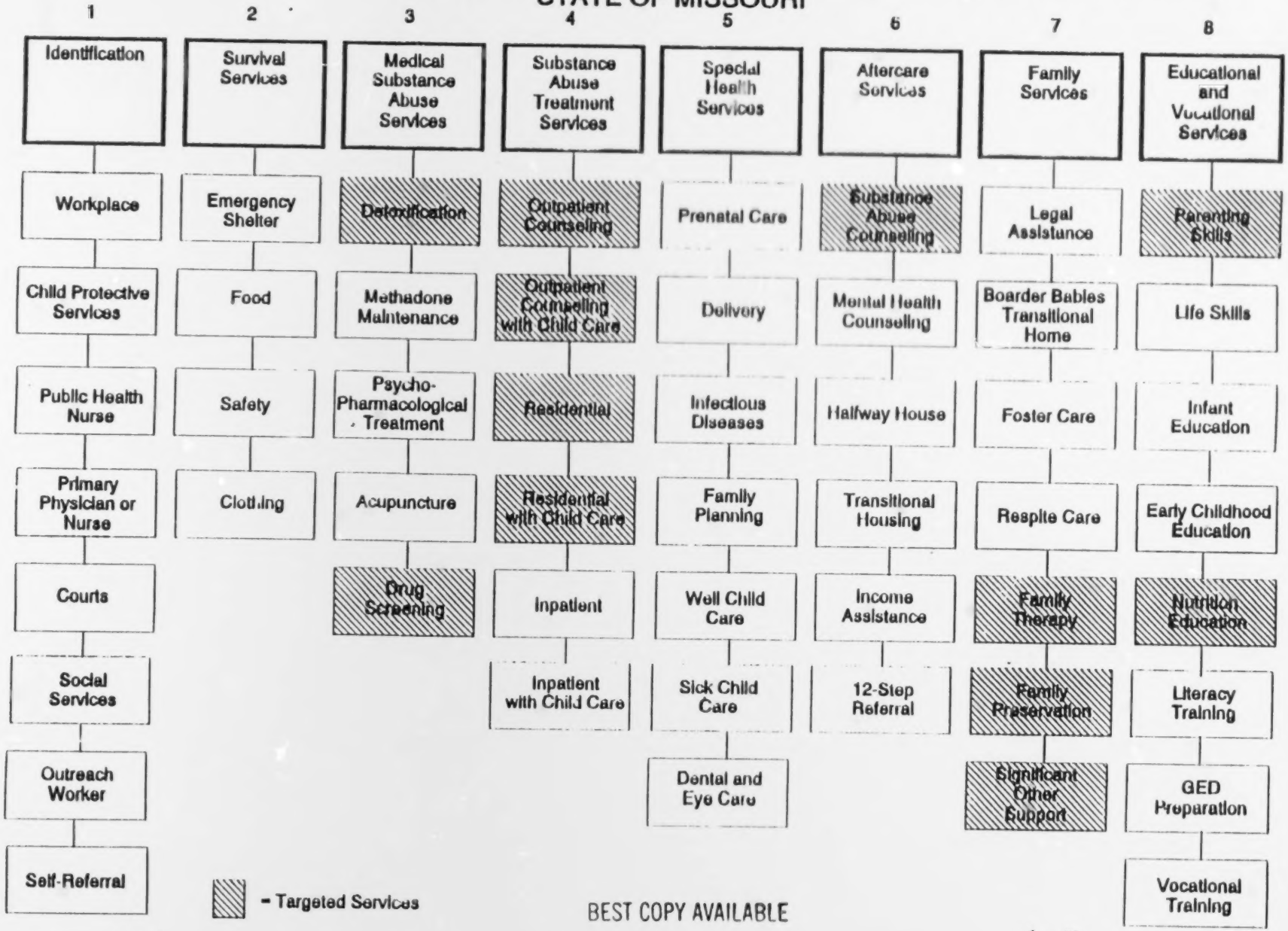
COMPREHENSIVE SUBSTANCE TREATMENT AND REHABILITATION PROGRAM (CSTAR)
STATE OF MISSOURI



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Objective #3: Develop Policy Recommendations and Options for Future Directions

Administration

There is no central strategy or philosophical approach that guides the diverse federal programs to fund criminal justice, prevention or treatment services for addicted pregnant and postpartum women and their children (APPWC). Funded programs exist in isolation of one another and are characterized by simultaneous gaps and overlaps. As a result the full benefits of the federal investment are not realized. The following is needed from the Administration:

1. A policy-making entity that collects data on existing APPWC programs, evaluates the results, and makes recommendations to the Administration.

2. An official policy-making entity that monitors and reports to the Administration the proposed changes in Medicaid, Welfare programs, WIC or other funding resources that may impact on APPWC.

3. An official policy on the relationship between criminal justice, prevention and treatment efforts targeted to APPWC.

4. An official policy on realistic and desired treatment outcomes for APPWC.

5 Cabinet or White House initiative to simplify, reorganize and coordinate the myriad of piecemeal programs for APPWC and to seek such legislation as would be necessary to accomplish this task.

Congress

Federal demonstration projects, the mechanism used most frequently for APPWC, favor the development of new programs over continuation or replication of existing programs. Several federal agencies and foundations may fund APPWC services in the same community, but

grantees may be unaware of each other's activities. This leads to sporadic availability of services with no coordination between funded services and no sustained development for comprehensive service delivery systems at the community level.

1. National Health Care Reform legislation should include mechanisms for stable funding for services for APPWC. States should have some maintenance-of-effort requirements that allow for year to year shifts.

2. National Health Care Reform legislation should include incentives for agencies to coordinate their activities and for grantees to work collaboratively as in the Robert Wood Johnson Foundation's Fighting Back initiative.

3. Congress should consider longer-term funding (at least 10 years) for promising research demonstration projects such as the NIDA Perinatal 20, since such expensive research projects are not likely to be funded through other sources. Substance abuse block grant money and Medicaid are not sufficient to cover the cost of randomization of subjects and expert research consultation and technical assistance. Such projects are needed for continued generation of longitudinal data to guide service delivery programs and to determine long-term effects of treatment interventions on drug-exposed children and their families.

4. Congress should consider the reorganization or expansion of existing programs such as VISTA, Headstart and public health nursing to provide family preservation, community coordination, out reach, transportation, case management and other services for APPWC.

5. Congress should consider reimbursement through Medicaid or other national health reform mechanisms for substance abuse treatment services rendered by nurses, social workers, psychologists and addiction counselors, because it is cost effective.

6. If Congressional jurisdictional reforms proceed, they should address the fragmentation of authority and legislation in this area.

States

State laws that include mandatory treatment for substance abusing individuals may be passed in states that have limited resources or treatment slots. Federal mandatory sentencing laws severely limit the actions that judges may take in drug cases.

Federal funds flow into states on parallel, but rarely coordinated tracks, often supporting similar or overlapping services. States are not given advanced information about federally funded demonstration projects within their domain, even though they are expected to fund continuation of such projects. Nor are they provided with research findings on what works or does not work.

1. State legislators and judges need education on the most effective ways for the criminal justice and the substance abuse treatment systems to work productively together.

2. States need mechanisms such as alternative dispute resolution or diversion methods for coordinating and maximizing the efforts of the criminal justice system and the substance abuse treatment system.

3. TASC model programs should be expanded to improve identification, evaluation and referral of APPWC to treatment as an alternative to criminal prosecution.

4. States should designate specific public housing sites to be half-way houses or drug free apartments for APPWC.

5. States need a mechanism for tracking funded services within their jurisdiction and for providing information about resources for comprehensive services for APPWC. This tracking may be accomplished best through a designated position in the Governor's office within each state.

Service Providers

Few primary care providers and mental health professionals are trained to meet the diverse needs of APPWC. In addition to deficiencies in substance abuse treatment competence, they lack skills in interagency cooperation and interdisciplinary collaboration. Substance abuse counselors lack skills in the medical treatments required by APPWC.

1. Primary care providers and mental health professional need specific protocols within their own educational systems that address comprehensive alcohol, drug and mental health treatment for APPWC.

2. Primary care providers, mental health professionals and substance abuse counselors need training in interdisciplinary and interagency coordination as part of their specialized educational system.

3. Service providers need to consider hot lines and electronic communications systems to indicate the availability of housing, treatment beds or alternative services appropriate for APPWC.

Foundations

Several gaps exist within federal and state funding programs for APPWC. They include:

1. Dissemination to policymakers on what works and doesn't work for APPWC.

2. Bridge grants to assist the transition from federal demonstration grant to stable funding.

3. Technical assistance to states and treatment providers to maximize the use of Medicaid reimbursement for APPWC.

4. Development of a directory to cover all funded projects for APPWC.

5. Assistance to service providers in developing culturally sensitive approaches.

6. Assistance to service providers in developing appropriate treatment interventions for male partners of APPWC.

7. Assistance to service providers in developing burnout interventions for clinicians and community workers who work with APPWC.

APPENDIX A:

THE LEGAL SYSTEM AND MATERNAL DRUG ABUSE

The criminal justice and child protection systems play a significant and unique role in the problem of substance abuse because they authorize the government to identify and intervene in the lives of drug-dependent female offenders and their families.

Female Incarceration and Drug Treatment

In 1989, the Office of National Drug Control Policy (ONDCP)[2] stated that incarceration presents a opportunity to provide drug treatment and recommended that prison make provision of drug treatment a priority (ONDCP, 1989). ONDCP also identified pregnant substance abusing women as a target population for priority treatment by the States and stated that the federal government would support research and demonstration projects directed toward this population. Drug treatment, however, receives far less federal program funding than traditional law enforcement efforts. In 1989, $3.6 billion dollars was devoted to traditional law enforcement efforts whereas $542 million was earmarked for treatment programs (Horgan et al., 1991).

The bulk of federal direct services and extramural funding available to the federal, state and local criminal justice systems support law enforcement efforts related to reducing the supply of illegal drugs, identifying illicit drug users, and prosecuting and incarcerating those who possess and sell illegal drugs and commit related crimes. A small percentage goes to drug

[2] The Office of National Drug Control Policy (ONDCP) was created by Congress in 1986 as part of the Anti-Drug Abuse Act of 1986. The agency is responsible for coordinating and overseeing the federal agencies responsible for implementing policies, objectives and priorities established under the President's National Drug Control Strategy. This office provides no program funding.

treatment.

Provision of the types of services included in comprehensive drug treatment programs believed necessary for drug-dependent female offenders may conflict with punitive correctional philosophies. There is also emphasis upon "equal treatment" of male and female inmates which some believe translates into less adequate care for female inmates (Rafter, 1992).

There has been no federal funding program earmarked for drug abuse research or treatment for pregnant and female offenders, however some recent funding and policy initiatives are directed toward these populations.

Table 1 shows the funding for drug treatment programs at the four federal prisons housing only female inmates. No information was available on the numbers of pregnant inmates included.

Table 1:

Drug Treatment Funding in Federal Women's Prisons

PRISON	FY90	FY91	FY92
Lexington	$50,000	$50,000	$50,000
Alderson	$30,000	$30,000	$30,000
Bryant	$30,000	$30,000	$30,000
Pleasanton	$30,000	$30,000	$30,000

According to a BOP spokesperson who heads the Female Offender Section, there is treatment on demand for all female offenders. There are a total of 250 treatment beds for females in the all female correctional institutions at Lexington, KY, Alderson, West Virginia,

Bryant, Texas, and Pleasanton, CA. Each of the four federal women's prisons is reported to have a comprehensive drug treatment program. Although there are drug treatment programs in all federal prisons housing both male and female inmates, there is no breakdown of services and costs expended on female inmates.

The Federal Bureau of Prisons (BOP) has recently begun to solicit contracts for the operation of community correctional centers (CCCs) throughout the country. In 1991, the BOP reports that 595 women were sentenced to CCCs. The Bureau has developed special guidelines for CCC contractors that specifically address female offender needs for parenting skills training, substance abuse treatment, career counseling and money management.

The Bureau has also begun to use CCCs for pregnant inmates. In February 1990, the Bureau and a Texas program, Mothers and Infants Together (MINT) began a pilot study to provide prenatal and postnatal services for pregnant inmates.[3] Based upon the successful results of this pilot, the Bureau has initiated a national policy of using CCC placement for pregnant inmates. This policy establishes residential programs for pregnant inmates within a 50 mile radius of the correctional institution to which the women was sentenced.

The BOP has also begun to address release preparation needs of female offenders. In 1992, a BOP Milwaukee pilot project addressed parenting, substance abuse, career counseling and money management issues with female inmates scheduled for release.

[3] This program permits pregnant inmates to be transferred to a CCC facility a short time before the birth of their child and to remain with their infant for 2 months after birth.

State Response

There are no federal or state laws that specifically make fetal harm by the mother a crime.[4] State prosecutors, however, have charged women with crimes for exposing their fetuses to drugs under a variety of existing laws that were not intended when passed to apply to this type of situation (Paltrow, 1992). These laws include criminal child support statutes, child abuse and neglect statutes, contributing to the delinquency of a minor, or delivery of drugs to a minor.[5] One source reports that 167 pregnant women in 24 states have been arrested under such laws.[6] In most of these cases, the women pled guilty or accepted plea bargains. In the 21

[4] Substance abuse by pregnant women raises cutting-edge and politically-sensitive legal issues in the United States. Regulation of the maternal-fetal relationship presents one of the greatest challenges to our contemporary legal system. There is no legal authority in the United States that prohibits drug-dependent women from bearing children. See, Eisenstadt v. Baird, 405 U.S. 438 (1972).

[5] Laws differ widely from state to state and even enforcement within a particular state may vary widely. Criminal laws may be arbitrarily enforced against certain women and not others because prosecutors for the state have considerable discretion in deciding against whom to bring criminal charges. Prosecutors are usually elected to office therefore personal ambition and political agenda may motivate some of them. One commentator has questioned prosecutor motivation in stretching narcotics laws against pregnant women as a method of fetal protection because criminal jurisdiction over these women could be obtained under the same narcotics laws without implicating fetal harm. See, Chavkin, D. (1992). "For Their Own Good": Civil Commitment of Alcohol and Drug-Dependent Pregnant Women. South Dakota Law Review, 37, 225-288. Another has stated that criminally prosecuting pregnant or post-partum women is a way for the government "to appear concerned about babies without having to spend any money, change any priorities, or challenge any vested interests. See, Pollitt, K. (1990). Fetal Rights, A New Assault on Feminism: Laws Protecting the Fetus from the Mother. The Nation, 250, 409, 410-11.

[6] Id. In 1986, Pamela Rae Stewart was arrested and charged with violation of a California criminal child abuse statute that made it a crime for a parent of a minor child to willfully omit to furnish necessary medical services to her child. In this case, the "minor child" was a fetus the mother had allegedly abused by disregarding her physician's advice to discontinue amphetamine use during her pregnancy. The California statute under which she was charged had been amended in 1923 to state that a "child conceived but not yet born is to be deemed an existing person" and was intended to require men to support children of women they

cases that were challenged, all were overturned or dismissed by the courts.[7]

A number of legal commentators have called for legislatures to pass specific fetal protection laws, including laws that would subject women to retrospective criminal liability for all damaging acts and omissions before birth, and for failure to undergo certain prenatal care (Harvard Law Review, 1988). A review of these legislative proposals noted that a woman could be held criminally liable for not eating well, for smoking, drinking alcohol, using other drugs, including prescription or over-the-counter remedies, or exposing the fetus to workplace hazards (Thompson, 1989).

Even if criminalization of prenatal drug exposure had succeeded in punishing the mother, these actions may have serious adverse consequences for the child despite the purported effort to save the child. For example, some have documented serious inadequacies in drug treatment and medical care available to pregnant inmates as well as the ready availability of legal and illegal

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impregnated.

Jennifer Johnson was the first woman convicted under a Florida narcotics law that prohibited the delivery of a controlled substance to a minor. Johnson v. State, (No. 77,831), 1992 Fla. LEXIS 1296; 17 Fla. Law W.S 473 (July 23, 1992). Johnson was charged with two counts of illegally delivering cocaine to her two minor children. Previously, Johnson voluntarily had attempted to seek drug treatment but was turned away. The state crafted a novel argument in support of her conviction--it argued that Johnson had delivered cocaine to her two children via blood flowing through the children's umbilical cords within minutes after their expulsion from the birth canal and before the cords were severed. The prosecutors tried this unusual approach because courts in other states rejected the application of criminal child abuse statutes to a fetus, which was not recognized as a legal person for purposes of the criminal statutes. See State v. Gethers, 585 So.2d 1140; Reyes v. Superior Court, 141 Cal. Rptr. 912.

[7] In overturning the decision in the Johnson case, supra, the Florida Supreme Court overturned stated that it "declines the State's invitation to walk down a path that the law, public policy, reason and common sense forbid it to tread."

drugs in prisons (Barry, 1989).

Many argue that because drug addiction is compulsive behavior, drug addiction is not susceptible to the effects of deterrence (Roper, 1992). Moreover, the fear of criminal prosecution may keep pregnant substance abusers away from vital prenatal care exacerbating possible fetal harm.

Women who abuse both legal and illegal drugs may be deprived of custody of their children.[8] In some states, fetal drug exposure alone has been viewed as grounds for loss of custody. The courts have ordered removal of children from parents who are substance abusers solely on the basis of fetal drug exposure.[9]

The threat of loss of child custody may act as a deterrent to substance abuse both during pregnancy and after. The threat of loss of custody may not deter drug use by addicts and may result in pregnant women foregoing necessary prenatal care to avoid detection of their dependence (Cole, 1990). Some drug treatment professionals argue, however, that potential loss of child custody provides the incentive to enter and successfully complete drug treatment (Goldsmith, 1990). Programs that provide drug treatment in cases of adjudicated or suspected

[8] Under the doctrine of parens patriae, American law recognizes that the government has an "independent interest in the rearing and welfare of children." See e.g. Hawaii v. Standard Oil Co., 405 U.S. 251 (1972). The American child protection laws reflect a complex, time-consuming process that is characterized by the tension between keeping families intact and removing children from hopeless situations. Each state has its own child protection system.

[9] See e.g., In Re Ruiz, 500 N.E. 2d 935 (Ohio Com. Pl. 1986) (The Court held that a child has a right to begin life with a sound mind and body, that a viable fetus is a child under the existing child abuse statute, and that harm to the fetus may be considered abuse under the child abuse statute); In Matter of Baby X, 293 N.W. 2d 736 (Mich. App. 1980) (This court also ruled that prenatal drug addiction, alone, may properly be considered child neglect or abuse for purposes of temporary but not permanent custody).

child abuse and neglect may be most effective in protecting children as placement in foster care or adoption may not be most beneficial to the child. In 1980, Congress passed the Adoption Assistance and Child Welfare Act mandating that state agencies receiving federal funds make "reasonable efforts" to keep families together and avoid placing a child in foster care. The purpose of this law is to provide parents with the services they need to remain intact by improving their ability to care for their children to prevent removal of children to overburdened foster care system. Such funds may be available for parental drug treatment.

Women's Health Care in Correctional Settings

There has been no ongoing program coordination between the Department of Health and Human Services and the Department of Justice in carrying out substance abuse research or treatment programs in correctional facilities and child welfare systems.

Health care services for women, particularly pregnant inmates, which are more costly to provide than male health care, are believed to be very limited. No national standards for medical and substance abuse management of female or pregnant offenders could be identified.

Availability of Drug Treatment in State Correctional Systems

Although the federal government provides funding to state criminal justice systems, there is no federal source of information that indicates how many federal dollars are used to address pregnant offenders. The major source of federal funding available to state and local correctional facilities permits these agencies to expend their grant funds on 21 program areas. Even though two of the permissible programs include drug treatment for inmates, there is no mandate that

states use the grant funds for any particular purpose. In addition, reporting requirements for use of these grant funds do not require states to report information by gender.

Table 2 shows federal program funding for FY 1990 and 1991 spent by those states reporting data on drug treatment programs that were described as specifically for female offenders. This list does not include those state prison drug treatment programs available to both male and female inmates. There were no data available on the number of pregnant offenders provided with drug treatment.

Table 2:

States' Use of Federal Block Grant Funds for Drug Treatment for Female Offenders

STATE	FUNDING FY90(in millions)	FUNDING FY91(in millions)
AL	$192,853	
CO		$114,010
DC	$300,000	
FL		$81,000
IA		$24,609
MA		$83,389
NY		$458,900
NV	$57,000	
OH	$159,002	$13,852
OR	$147,610	$106,000
PA	$86,500	$222,977
PR		$12,436
TN	$8,438	
UT		$39,137
TOTALS	$951,403	$1,156,310

The TASC Model

Treatment Alternatives to Street Crime (TASC) refers to community-based programs that serve as a bridge between the correctional system and the substance abuse treatment community. TASC programs receive funding from federal grants through the BJA, state legislative earmarks and state criminal justice agencies, private funds and client fees. TASC was developed in 1972 through federal legislation and currently operates 185 programs in 28 states and the territories. The state TASC organizations are represented at the national level by the National Consortium of TASC Programs (NCTP).

In the early 1970's, the federal government acknowledged the strong link between substance abuse and crime and began to explore ways to interrupt this relationship. The Law Enforcement Assistance Administration within the Department of Justice, the White House Special Action Office for Drug Abuse Prevention and the predecessor agency to the National Institute on Drug Abuse cooperated. The project was funded by the Drug Abuse Office and Treatment Act of 1972. The first TASC program opened in Wilmington, Delaware in August, 1972 and provided pretrial diversion for opiate addicts with nonviolent criminal charges who were identified through urine tests and self-reports.

Although TASC model programs have been developed to identify, evaluate and refer substance-abusing offenders to treatment as an alternative to incarceration and are designed to be easily replicated in any criminal justice setting and for special populations such as female, juvenile and adolescent offenders. TASC does not provide treatment services within the correctional setting. The TASC case management approach moves the drug-dependent offender through the criminal justice process and into a community-based drug treatment facility while

simultaneously monitoring the offender as an adjunct to criminal justice supervision. TASC describes its operation as providing a unique treatment linkage at any point in the criminal justice process, from the pretrial stage to parole. The TASC model includes the following features:

1. identification of the drug-dependent offender through screening procedures that determine client eligibility for treatment intervention
2. assessment of the offender's severity of drug dependency and appropriateness for treatment placement
3. referral to appropriate community treatment services
4. individual case management to ensure program compliance (e.g. urine screening and other monitoring)

This treatment model is described as being fully replicable in urban, suburban and rural settings and as responsive to special populations including female and pregnant offenders. Since its inception, however, TASC notes that most of its clients have been adult male offenders. TASC states, however, that in recent years it has made efforts to reach juveniles and female offenders. In 1990, TASC received a grant from the BJA to develop a model program for treatment of substance-abusing female offenders, including pregnant offenders. There is no information available on the extent to which this new model has been incorporated into the TASC programs.

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APPENDIX B:

THE OTI CRITERIA FOR COMPREHENSIVE TREATMENT

1. Intake and Assessment Protocol
2. Same Day Intake Services
3. Clinical Case Management
4. Preventive and Primary Medical Care
5. Medical Testing for TB, HIV, STDS
6. Pharmacotherapeutic Interventions
7. Substance Abuse Counseling
8. Life Skills Training
9. Peer Support Groups for Clients with HIV, or History of Sexual Abuse
10. Liaison with Criminal Justice
11. Facilitation of Patient Participation
12. Alternative Housing
13. Aftercare and Self-Help
14. Outcome Evaluation

APPENDIX C:

RESIDENTIAL REHABILITATION PROGRAMS FOR SUBSTANCE ABUSING WOMEN WITH THEIR CHILDREN COMPREHENSIVE CORE SERVICES

Maria Vandor, New York State Division of Substance Abuse Services

1. *Assessment for Mother*: Addiction history, family history, legal issues, comprehensive medical history, pregnancy, mental health, vocational and employment, social and leisure, housing and financial.

2. *Assessment for Child*: Medical, psychological, family history, developmental needs, abuse, educational needs, day-care needs.

3. *Adult Substance Abuse Counseling Services*: Case management, detoxification, individual and group counseling, informational sessions on substance abuse, support groups with alumni counselors, family counseling.

4. *Specific Instructional Sessions*: Domestic violence, sexual abuse and incest, assertiveness training, self-defense, post traumatic stress.

5. *Life Management Services*: Personal care and hygiene, home management, accessing community services, nutrition and meal preparation, accessing health care services.

6. *Age Appropriate Children's Services for Infants and Toddlers*: Childcare; well-baby care; therapeutic nursery; developmental screening; speech, occupational, play and social skills therapy.

7. *Age Appropriate Children's Services for Pre-school Children*: Headstart, mental health, substance abuse prevention, linkages with Early Direction Centers, licensed day-care, developmental screening.

8. *Age Appropriate Children's Services for School-Age Children*: Mental health counseling, peer support groups, family life education, linkages with schools and committees on special education, assessment of learning disabilities, after-school activities, sex education, substance abuse education, literacy and remedial education, vocational and career education and teen parenting education.

9. *Parenting Services*: Child rearing and parenting skills, parent support groups, first aid and CPR, education on environmental safety, respite and childcare services, instruction on child health issues.

10. *Specialized Health Services for Children*: Routine outpatient and emergency services, health classes, dental care, medication and physical examination, medical accommodations for sick children.

11. *Specialized Health Services for Mothers*: Prenatal and postpartum care, preventive health behavior instruction, family planning, sexually transmitted information and treatment, dental care.

12. *Legal Services*: Legal case management, representation with criminal justice system, foster care and child protective services assistance, child visitation and support assistance, disability assistance, child custody, wills, and living wills.

13. *Recreational Services*: Indoor and outdoor recreational activities, structured parent/child activities, unstructured activities, summer programming.

14. *Discharge/Transitional Services*: Day and outpatient services, supportive living environments, self-help groups, independent living, respite care, home-maker service, child care, employment, financial assistance, transfer or discharge planning, transportation.

15. *Staff Training and Inservice*.

APPENDIX D:

OSAP NATIONAL RESOURCE CENTER FOR THE PREVENTION OF PERINATAL ABUSE OF ALCOHOL AND OTHER DRUGS

EXEMPLARY TREATMENT WORKSHOP

Experts in the perinatal addiction treatment field, including government officials, state alcohol and drug administrators, Medicaid specialists, federal demonstration project grantees, were convened to discuss exemplary strategies in treatment. They were asked to identify and prioritize the most important services for drug exposed children and their families. The participants selected four categories: children, women, family and collaborative services for this exercise. In order of importance, they identified the following services:

CHILDREN

1. special need childcare
2. developmental services
3. mental health services

WOMEN

1. residential drug treatment
2. outpatient drug treatment with childcare
3. medical care/prenatal care
4. mental health services
5. literacy and vocational training

FAMILY

1. medical care
2. intensive family preservation services
3. mental health services
4. parenting skills
5. family planning

COLLABORATIVE SERVICES

1. inter-agency training and team building
2. multi-agency case review and case planning
3. research, evaluation, dissemination of findings
4. public policy coalition building

APPENDIX E:

U.S. DEPARTMENT OF AGRICULTURE
FUNDING SOURCES FOR COMPONENTS OF THE CHPR COMPREHENSIVE SERVICE DELIVERY MODEL

PROGRAM	DESCRIPTION	FUNDING SOURCE	FUNDING FY90	FY91	FY92
Child and Adult Care Food Program	This program assists states in maintaining food service programs for children, elderly or impaired adults in non-residential institutions providing care, family day care homes for children, and private centers that receive funding under Title XX.	DOA	$814.0 m	$1.0 b	$1.2 b
Special Supplemental Food Program for Women, Infants, and Children (WIC Program)	This program supplies supplemental nutritious food and nutrition education to low-income pregnant and postpartum women, infants and children who are identified to be at nutritional risk. Funding levels for FY90 reflect grants for food and administration and program services. Funding levels for FY91 and FY92 reflect grants for food only.	DOA	$2.1 b	$1.8 b	$2.0 b

GENERAL SERVICES ADMINISTRATION
FUNDING SOURCES FOR COMPONENTS OF THE CHPR COMPREHENSIVE SERVICE DELIVERY MODEL

PROGRAM	DESCRIPTION	FUNDING SOURCE	FUNDING FY90	FY91	FY92
Surplus Personal Property Program	This program transfers the Federal government's surplus personal property to states for distribution to eligible entities including state and local public agencies, non-profit educational and service organizations, and homeless service providers. Property must be used for carrying out public purposes, such as drug treatment.	GSA	$513.0 m	$550.0 m	$600.0
Surplus Real Estate Program	The Federal government transfers and sells surplus property (i.e. land, land and buildings and buildings only) to other Federal agencies and nonprofit agencies. The property may be obtained free of charge for health and educational uses, including drug treatment.	GSA	n/a	n/a	n/a

U.S. DEPARTMENT OF EDUCATION
FUNDING SOURCES FOR COMPONENTS OF THE CHPR COMPREHENSIVE SERVICE DELIVERY MODEL

PROGRAM	DESCRIPTION	FUNDING SOURCE	FUNDING FY90	FY91	FY92
Chapter 1	This formula grant program, authorized under the Elementary and Secondary Education Act, provides supplementary educational and related services to educationally disadvantaged children generally under 18 years of age. Children eligible for services are those who have low academic achievement and are enrolled in schools serving low-income students. Children who were exposed prenatally to drugs may be eligible for Chapter 1 services if they have poor academic performance and are generally disadvantaged. No data is available on the number of drug-exposed children served under Chapter 1.	ED	*	*	$6.1 b
Drug-Free Schools and Communities Act Counselor Training Grants Program	Grants are awarded to establish, expand or enhance programs and activities for the training of counselors, psychologists, social workers or nurses who are providing drug abuse prevention, counseling or referral services in elementary and secondary schools.	ED	-	$3.4 m	$3.4 m
Drug-Free Schools and Communities Act Demonstration Grants to Institutions of Higher Education Program	Grants are awarded to institutions of higher education for model demonstration programs coordinated with local elementary and secondary schools for the development and implementation of quality drug and alcohol abuse and prevention programs.	ED	$5.0 m	$4.9 m	$5.1 m
Drug-Free Schools and Communities Act Formula Grant Program	Formula grants are provided to states and local organizations to provide school and community-based drug and alcohol abuse education, prevention, early intervention and rehabilitation referral.	ED	$436.0 m	$492.0 m	$492.0 m
Drug-Free Schools and Communities Act Drug Prevention Programs in Higher Education	Institutions of higher learning receive grants to establish, operate and improve programs of drug and alcohol abuse and prevention for their students.	ED	$14.2 m	$14.1 m	$14.3 m
Drug-Free Schools and Communities Act Emergency Grants Program	Assistance is provided to local educational agencies that demonstrate significant need for additional assistance to combat drug and alcohol abuse by students.	ED	$24.7 m	$24.3 m	$30.3 m

Drug-Free Schools and Communities Act Federal Activities Grants Program	Assistance is provided to state and local education agencies, institutions of higher education and nonprofit organizations to support drug and alcohol abuse education and prevention activities.	ED	$3.8 m	$5.0 m	$6.5 m
Drug-Free Schools and Communities Act Regional Centers	The purpose of this program is to fund five regional centers that provide training, technical assistance and information to help their regions' schools and communities eliminate alcohol and drug abuse among young people.	ED	$16.0 m	$16.0 m	$16.2 m
Drug-Free Schools and Communities Act Training of Teachers, Counselors and School Personnel Program	Assistance is provided to state educational agencies, local educational agencies and institutions of higher education to establish or enhance programs for the training of school personnel including elementary and secondary school teachers concerning drug and alcohol education and prevention.	ED	$23.7 m	$20.0 m	$20.0 m
Early Education Program for Children with Disabilities	This program funds early childhood research institutes to generate and disseminate new information on preschool and early intervention for children with disabilities and their families. In FY91, the Universities of Kansas, Minnesota and South Dakota received a five year grant to operate an institute on substance abuse and to develop and disseminate collaborative interventions for infants, toddlers and preschoolers who are developmentally delayed, including those who at risk of developmental delay because due to prenatal drug exposure. This program also funds demonstration and outreach projects to develop and replicate program that serve as models in serving disabled infants and young children. In FY91, for example, three new demonstration projects and one outreach project on children who were exposed prenatally exposed to drugs received funding. Project CAPS: Caregiver and Parent Support at The George Washington University received funding to develop and implement a comprehensive identification, intervention and referral program for at-risk infants, their families and child care providers.	ED	$.8 m	$.7 m	$.7 m
Early Intervention Program	Part H of the Individuals with Disabilities Education Act (IDEA) authorizes a formula grant program to assist each state to develop a statewide, comprehensive and coordinated system of early intervention services for infants and toddlers with disabilities and their families. Infants and toddlers under the age of 3 eligible for services under part H may include, at a state's discretion, children at risk of developmental delay due to prenatal drug exposure. Services may include physical therapy, special instruction and family training. No data are available on the number of drug-exposed infants served under the part H program.	ED	*	*	$175.0 m

Even Start	This discretionary grant program, authorized under the Elementary and Secondary Education Act, provides education to disadvantaged children ages 1 through 7 and their parents who have not earned a high school diploma or its equivalent. Children who were drug-exposed in utero may be eligible for services. No data is available on the number of drug-exposed children served under the Even Start.	ED	*	*	$70.0 m
Research in Education of Individuals with Disabilities Program	These research projects are authorized under the Individuals with Disabilities Education Act (IDEA) Act. In FY91, one research project received funds to study the social development of children who were prenatally exposed to drugs.	ED	-	$.15 m	-
Special Education for Disabled Preschoolers	This formula grant program assists states with providing special education in the least restrictive educational setting to disabled children ages 3 through 5. Children who were exposed prenatally to drugs are eligible for special education. No data are available on the number of drug-exposed children served under this program.	ED	*	*	$320.0 m
Training Programs for Educators--Innovative Alcohol Abuse Education Programs	Grants are awarded to public and private organizations, agencies and institutions to train educations who serve children in grades 5 through 8 on problems associated with alcoholism in the family. In FY90, contracts were awarded for materials development.	ED	$2.0 m	$2.0 m	$2.0 m

* Funding information not available.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADDITIONAL FUNDING SOURCES FOR COMPONENTS OF THE CHPR COMPREHENSIVE SERVICE DELIVERY MODEL

PROGRAM	DESCRIPTION	FUNDING SOURCE	FUNDING (millions) FY90	FY91	FY92
Adoption Assistance Program	This program provides funds to states to assist in paying maintenance costs for AFDC and SSI-eligible children and children with special needs such as children with disabilities.	ACF	$124.9 m	$189.8 m	$202.0 m
Adolescent Family Life Demonstration Projects	These demonstration projects (1) promote adoption as an alternative for adolescent parents; (2) promote community and family-centered approaches to the problem of out-of-wedlock pregnancy by encouraging abstinence; and (3) establish comprehensive and integrated approaches to the delivery of care services for pregnant adolescents.	OASH	-	$5.4 m	$5.2 m
Alcohol and Drug Abuse Clinical or Service-Related Training	This program supports training for health and allied health professionals in issues related to alcohol and other drug abuse.	NIAAA	$3.8 m	$4.0 m	$5.0 m
Alcohol Research Programs	These research projects are designed to develop a sound, fundamental knowledge base which can be applied to the development of improved methods of treatment and more effective strategies for the prevention of alcoholism and alcohol-related problems.	NIAAA	$85.5 m	$92.7 m	$102.8 m
Child Abuse and Neglect Discretionary Activities	This program provides grants to improve services and explore the incidence, causes, and new ways to prevent, identify and treat child abuse and neglect. Specific funds are made available for projects in the area of child sexual abuse.	ACF	$13.5 m	$14.6 m	$14.6 m
Child Abuse and Neglect State Grants	This program provides formula grants to states to develop, strengthen and carry out state programs for preventing and treating child abuse and neglect. Recently, programs and procedures have been established for the identification, prevention and treatment for infants and children victimized by substance abusers.	ACF	$11.5 m	$19.5 m	$20.5 m

Child Care and Development Block Grant	This block grant serves children under age 13 who come from families with incomes at or below 75 percent of the state median income and reside with parents who are working, attending school or in a job training program. Children who need or receive protective services are also eligible for services. The purpose of the block grant is to offer services which improve the quality of child care and increase the availability of before- and after-school child care. Substance abuse providers who are licensed to provide child care may use these funds.	ACF	-	$750 m	$825 m
Child Welfare Services	This program provides formula grants to states for child welfare services. It matches state expenditures at a rate of 75 percent up to each state's share of appropriations. This program is designed to prevent and remedy child abuse and neglect, protect and care for children who are removed from their homes, and provide reunification and adoption services. Services may include case management, counseling, respite care, homemaker services and parenting education. States are reimbursed for services provided to all children, not just low-income populations.	ACF	$252.6 m	$274.0 m	$274.0 m
Child Welfare Training	Discretionary grants are awarded to institutions of higher learning to develop and improve education and training programs and resources for child welfare providers. Activities supported include upgrading information related to the effects of drug abuse.	ACF	$3.6 m	$3.6 m	$3.6 m
Communications Programs Aimed Toward the Prevention of Alcohol and Other Drug Problems	These programs are designed to stimulate the development and evaluation of promising communications-based models or innovative approaches to the prevention of alcohol and other drug abuse problems for high-risk and hard-to-reach audiences, particularly high-risk youth; foster the development and use of communication tools and products; and develop approaches to assist communities in improving the overall message for prevention and protection of those living in high-risk environments.	OSAP	$2.4 m	$2.6 m	$2.7 m
Community and Migrant Health Center Program - Comprehensive Perinatal Care Initiative	Community health centers received supplemental funding to provide case-managed prenatal and pediatric services to high-risk pregnant women and young children.	BHCDA	$31.6 m	$32.6 m	$42.5 m
Community and Migrant Health Center Program - Health Care for the Homeless Program	More than 100 community health centers received supplemental funding to provide primary health care and substance abuse treatment to homeless individuals and families.	BHCDA	$60.0 m	$51.0 m	$56.0 m

Community and Migrant Health Center Program - Substance Abuse Initiative	From FY89 to FY91, 43 community health centers received supplemental funding for the purpose of integrating the special service needs of substance abusers. Activities included direct service delivery and training and curriculum development for service providers.	BHCDA	$9.0 m	*	$0
Community Coalition Intervention Demonstration Projects to Support Health and Human Services Needs for Minority Males	These demonstration projects demonstrate ways to improve health and human services to minority males at high risk of (1) health problems, including alcohol and drug abuse and (2) social problems.	OASH	$2.4 m	$3.0 m	$5.0 m
Community Demonstration Grant Projects for Alcohol and Other Drug Abuse Treatment of Homeless Individuals	The purpose of this program is to implement and evaluate a variety of approaches to community-based alcohol/drug treatment and rehabilitation services for individuals with alcohol or other drug problems who are homeless or at risk of becoming homeless. Services are provided to a variety of populations, including women with children. The funding levels shown also include funds appropriated for the other research demonstration program, Cooperative Agreement Research Demonstration Program for Alcohol and Other Drug Abuse Treatment of Homeless Persons.	NIDA NIAAA	$16.4 m	$16.4 m	$16.0 m
Community Health Centers	This program supports the development and operation of community health centers which provide primary care services, supplemental health services and environmental health services to medically-underserved populations. The Centers serve primarily women and children, many of whom have substance abuse problems themselves or in their families.	BHCDA	$456.9 m	$478.2 m	$536.6 m
Community Partnership Demonstration Program	These demonstration projects are designed to encourage community leaders and diverse organizations in local communities to more effectively coordinate prevention programs and develop prevention initiatives. More specifically, it is anticipated that these projects will demonstrate that the development of broad-based support within the community can substantially contribute to the elimination of alcohol and other drug abuse.	OSAP	$41.3 m	$92.4 m	$106.8 m
Community Services Block Grant	This program provides block grants to states (1) to provide services and activities having a measurable and potential major impact on causes of poverty in the community; (2) to provide activities designed to assist low-income participants; (3) to provide on an emergency basis for the provision of supplies and services; (4) to coordinate and establish linkages between governmental and other social services programs to assure the effective delivery of services to low-income individuals; and (5) to encourage the use of entities in the private sector of the community in efforts to ameliorate poverty in the community.	ACF	$322.1 m	$349.4 m	$360.0 m

Community Services Block Grant Discretionary Awards - Community Food and Nutrition	This formula grant program awards a supplement to Community Services Block Grant recipients for the purposes of: (1) coordinating food assistance resources to better serve low-income populations; (2) assisting communities to identify potential sponsors of child nutrition programs and to initiate new programs; and (3) developing innovative approaches to meet the nutritional needs of low-income individuals.	ACF	$2.4 m	$2.4 m	$7.0 m
Community Youth Activity Program Demonstration Grants	These demonstration grants are provided to communities and national organizations for the purpose of establishing and evaluating innovative alcohol and other drug abuse prevention services for high-risk youth.	OSAP	$14.0 m	$14.2 m	$7.0 m
Community Youth Activity Program Block Grants (CYAP)	This formula grant program provides block grants to states to support local education, training and recreation projects for youth who are at risk of abusing drugs.	OSAP	$4.9 b	$4.9 b	$2.4 b
Community Youth Activity Program Projects of National Significance	Projects of National Significance receive 5 to 15 percent of the annual Community Youth Activities Program appropriation. These projects are designed specifically to stimulate the incorporation of drug and alcohol prevention components, such as recreational activities, into existing organizations serving high-risk youth. Funding for FY92 reflect the maximum appropriation for these activities.	OSAP	$1.1 m	$.5 m	$1.1 m
Co-morbidity Demonstration	This demonstration project is part of the Comprehensive Community Treatment Initiatives program. The purpose of this demonstration project is to provide drug treatment to dually diagnosed patients. In FY91, $1.9 million was spent on the Co-morbidity demonstration. The funding levels shown include all programs within the Comprehensive Community Treatment Initiatives program.	OTI NIMH	$6.6 m	$11.4 m	$11.9 m
Comprehensive Child Development Program	This demonstration program funds centers to offer intensive, comprehensive, integrated and continuous support services for infants, toddlers and preschoolers from low-income families to enhance their intellectual, social, emotional and physical development and to provide support services to their parents and other family members. Most centers offer drug treatment for parents. In FY92, three to five special emphasis grants were awarded to agencies that operated centers that recruit and enroll only families with known substance abusers.	ACF	$24.7 m	$24.4 m	$44.4 m

Conference Grant (Substance Abuse)	OSAP sponsors and supports conferences which coordinate, exchange and disseminate state-of-the art information about prevention and intervention of alcohol and other drug abuse to clinical and professional audiences. Some of these conferences deal specifically with the issues of substance abusing pregnant and postpartum women.	OSAP	$2.1 m	$2.0 m	$2.1 m
Crack Babies Program	Grants are awarded to develop and provide respite care for babies, including those who are drug-exposed and those with AIDS	ACF	*	$5.9 m	$5.9 m
Demonstration Grants for the Prevention of Alcohol and Other Drug Abuse Among High Risk Youth	This program provides funds to develop innovative approaches aimed at preventing alcohol and other drug use among youth. Funded projects are designed to identify and enhance protective factors while reducing the risk factors for using alcohol and drugs.	OSAP	$32.8 m	$45.5 m	$52.0 m
Demonstration Projects to Study the Effect of Allowing States to Extend Medicaid to Pregnant Women and Children Not Otherwise Qualified to Receive Medicaid Benefits	Authorized under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), these demonstration projects use Medicaid funds to test alternative insurance programs in three states: Florida, Michigan and Maine. The programs target uninsured children under 20 years of age and pregnant women with family incomes below 185% of the Federal poverty line who are not otherwise eligible for Medicaid. However, no states have targeted this coverage to pregnant women. Funding levels shown reflect the amount authorized, not appropriated, by OBRA 90.	HCFA	$10.0 m	$10.0 m	$10.0 m
Disaster Relief Assistance Grants for Drug Abuse Treatment	Following natural disasters, some states' drug treatment services were damaged severely. In response, this program provides grants to states to repair and restore drug treatment facilities, train staff on prevention and treatment of post-traumatic stress disorder, screen individuals for drug abuse, expand outreach activities, and train staff for referral of clients to appropriate services.	OTI	$1.8 m	$0	$0
Drug Abuse and AIDS Public Education Materials	This program provides radio and print materials aimed at IV drug users and their sexual partners. The materials deal with three issues: needle sharing, sexual relations and childbirth. Although no funds were appropriated for this program in FY 92, the contractor continued the program at no cost to the Federal government.	NIDA	$.99 m	$.99 m	$0
Drug Abuse Information and Treatment Referral Hotline	NIDA operates a hotline seven days a week and has answered over 250,000 calls since its inception in 1986. Hotline callers have received referrals to drug abuse treatment as well as information about drugs. Many of the callers are women who are in their childbearing years, some of whom are certainly pregnant and have a drug abuse problem.	NIDA	*	*	*

Drug Abuse Prevention and Education Relating to Youth Gangs	The purpose of this program is to reduce and prevent the participation of youth gangs in illicit drug activities. Activities supported by the program include: providing recreational activities for youth, educating youth about problems, informing gang members about drug treatment, and facilitating cooperation and coordination among local education, juvenile justice, employment, social service agencies, drug abuse treatment and referral and rehabilitation programs.	ACF	$14.8 m	$14.8 m	$11.0 m
Drug Abuse Prevention for Runaway and Homeless Youth	This program is designed to reduce and prevent the illicit use of drugs by youth who run away from home or who are homeless. Counseling, community education, training and information and other activities to increase the availability and coordination of local services to discourage drug abuse are provided.	ACF	$14.8 m	$14.8 m	$13.3 m
Drug Abuse Warning Network (DAWN)	The purpose of DAWN is to identify drug-related deaths. Information is collected from a nationally representative sample of hospital emergency rooms and medical examiners. Funding for data collections efforts is provided through the NIDA research program.	NIDA	•	•	•
Drug Services Research Survey	This survey gathered data from a national sample of 1,000 treatment services on the treatment of pregnant women and pregnancy status of clients.	NIDA	•	•	•
Family Planning Services (Umbrella Councils)	Grants are available to public and private not-for-profit entities to provide educational, counseling, comprehensive medical and social services to enable individuals to determine the number and spacing of their children.	OASH	$129.8 m	$134.7 m	$138.6 m
Family Violence Prevention and Services	The purpose of this program is to demonstrate the effectiveness of assisting states and Indian tribes in the prevention of family violence and to provide immediate shelter for victims of family violence and their dependents.	ACF	$8.3 m	$10.7 m	$20.0 m
Head Start	This program provides comprehensive health, educational, nutritional, social and other services primarily to low-income preschool children. Recognizing that one out of every five preschool children is affected by substance abuse, Head Start has funded projects to demonstrate ways that Head Start programs can work with community organizations to deal with the problems of substance abuse. These projects are aimed at encouraging families to participate in activities which are designed to reduce and prevent the incidence of substance abuse.	ACF	$1.4 b	$1.9 b	$2.2 b

Health Professions Education Program	This program supports clinical training in alcohol and drug abuse issues. The purpose of the program is to demonstrate effective models of integrating alcohol and other drug abuse teaching into medical and nurse education curricula. Issues related to pregnant substance abusers and their drug-exposed infants are included.	NIDA NIAAA	*	*	*
Homeless Demonstration Grant Program	Cooperative agreements are awarded to grantees to demonstrate effective interventions for homeless individuals with substance abuse problems. Interventions are measured in terms of: the reduction in substance abuse; the increase in shelter and residential stability; the enhancement of the economic or employment status; the improvement in health status; and the increase in cooperation among service agencies addressing the multiple needs of substance-abusing homeless individuals.	NIAAA	$16.4 m	$16.4 m	$16.0 m
Indian Health Service Research	Grants are awarded to Federally recognized Indian tribes and Indian Health Service components to conduct research and developmental activities in areas of Indian health care which further the performance of health responsibilities of the Indian Health Service.	IHS	$0	$ .6 m	$.6 m
Integrated Primary Care and Substance Abuse Treatment Services	Demonstration grants are provided to service providers which are able to demonstrate how to link community-based primary care programs to substance abuse treatment programs in an effort to improve the effectiveness of substance abuse treatment and combat the spread of AIDS. Comprehensive health and substance abuse services are provided to injection drug users, other drug users, their sexual partners and family members.	BHCDA	$8.9 m	$8.4 m	$8.0 m
Job Corps Project	This project is part of OTI's Comprehensive Community Treatment Initiatives and is a collaborative effort with the Department of Labor. The purpose of the program is to provide drug treatment resources within labor training programs. In FY91, $1.2 million was devoted to the Job Corps Project. Funding levels shown include all of the Comprehensive Community Treatment Initiatives.	OTI	$6.6 m	$11.4 m	$11.9 m
Maternal and Child Health Block Grant (Title V)	Funds are distributed to states which can use the monies for a variety of activities aimed at assuring access to quality maternal and child health services, especially for those with low incomes and living in areas with limited availability of health services. Pregnant substance using women and drug-exposed children may qualify for services provided by the MCH block grant.	MCHB	$553.6 m	$587.3 m	$650.0 m

Media and Communications Activities	NIDA has developed a number of media materials including the Capsule on Drug Abuse and Pregnancy and NIDA Notes, both of which have been distributed widely. NIDA plans to develop materials which will promote the hotline for women, provide more guidance to drug abuse treatment and prevention practitioners on outcomes of new research and develop a video news release and other materials.	NIDA	•	•	•
Medicaid	Medicaid is a Federal/state means-tested entitlement program for certain low-income persons. Traditionally, Medicaid eligibility has been tied to receipt of cash assistance under the Aid to Families with Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program. Medicaid was not designed to be a primary funding stream for alcohol and other drug abuse treatment. Generally, however, Medicaid will pay for hospital-based, methadone maintenance and drug-free outpatient treatment. Medicaid will pay only for drug treatment in nonhospital-based residential facilities with 16 or fewer beds. Women with dependent children who wish to enter a residential treatment facility that doesn't accept children must place their children in foster care. At that time, they frequently lose their Medicaid eligibility. Funding levels reflect total funding for the entire Medicaid program.	HCFA	$72.5 b	$92.4 b	$118.9 b
Methadone Monitoring Program	The FDA monitors narcotic treatment programs to determine compliance with narcotic treatment standards. In recent years, FDA inspectors have identified areas in need of assistance to improve operations and assure compliance including: the availability and provision of appropriate counseling and support services; the conduct of proper screening procedures to prevent the provision of treatment services to pregnant women; and the conduct of appropriate client interviews to assess degree of addiction and document personal history.	FDA	•	•	•
Metropolitan Area Survey	This survey is designed to study the prevalence, incidence and health consequences associated with drug abuse in the Washington, D.C. metropolitan area. Funding for data collection activities is supported by a set-aside from the ADMS block grant.	OTI	•	•	•
Migrant Health Centers Grants	Grants are awarded to support the development and operation of migrant health centers and projects which provide primary health care services, supplemental health services and environmental health services which are accessible to migrant and seasonal farm workers and their families.	BHCDA	49.3 m	$51.7 m	$51.7 m
Military Facilities Initiatives	This collaborative effort seeks to use unutilized and underutilized military facilities for drug treatment. Funding levels reflect estimated value of properties. To date, however, no drug treatment program has taken possession of a building at a closed base.	OTI NIDA	$115.5 m	$200.0 m	•

Model Comprehensive Drug Abuse Treatment Program for Critical Populations	The goal of this program is to establish national prototypes for providing a continuum of comprehensive therapeutic services to improve treatment outcomes for populations determined to be in critical need of assistance.	OTI	$24.2 m	$23.5 m	$23.8 m
Model Criminal Justice Drug Abuse Treatment for Non Incarcerated Juvenile Justice Populations	Grants are awarded to states to improve the treatment for individuals who are suited for diversion from incarceration and criminals who have a great probability of drug use and criminal recidivism. The goal of this program is to fund model drug abuse treatment diversion, probation and parole treatment programs. Funded activities may include screening and referral strategies, case management strategies, enhancement of addition treatment service plans and service delivery strategies.	OTI	$4.0 m	$6.0 m	$6.1 m
Model Comprehensive Drug Abuse Treatment Programs for Adolescents/Juvenile Justice	These programs are designed to assist states in enhancing and expanding the availability of model comprehensive drug abuse treatment for adolescents and juvenile offenders. The goal of the program is the reduce the frequency with which adolescents interact with juvenile justice agencies and/or engage in criminal behavior because of their addictive disorders.	OTI	-	$11.0 m	$10.9 m
Model Drug Abuse Treatment Programs for Correctional Settings	This initiative receives a portion of the funds from OTI's treatment improvement grants program. The purpose of this program is to enhance the quality of existing drug abuse treatment for criminals by providing funds for model approaches that link treatment to criminal justice.	OTI	$3.7 m	$3.7 m	$3.7 m
Model Drug Abuse Treatment Programs for Non-Incarcerated Criminal Justice Populations	This program receive a portion of OTI's treatment improvement grant funds. Grants are provided for the improvement of treatment for individuals who are suited for diversion from incarceration and criminals with great probability of drug use and criminal recidivism.	OTI	$4.1 m	$6.0 m	$6.0 m
National Clearinghouse for Alcohol and Drug Information (NCADI)	NCADI is a comprehensive Federal resource for information on alcohol and other drugs. It develops and distributes printed and audiovisual materials, publishes a newsletter and provides technical support. One of its activities includes the Regional Alcohol and Drug Awareness Resource (RADAR) Network. RADAR, consisting of state and national organizations, disseminates materials and provides feedback about the nature of drug and alcohol issues. The funding level reflects the amount awarded to a contractor to run the project for four years, beginning in 1989.	OSAP	$14.0 m	*	*

National Training System	This program is designed to develop curricula and deliver training to health professionals such as physicians and social workers, community leaders and prevention professionals. The system is comprised of six initiatives: the community partnership training program; the health professional education clinical training program, the national volunteer training center, the faculty development program in alcohol and drug abuse, training for those with access to at-risk populations, and the substance abuse counselor training program.	OSAP	$26.0 m	$26.0 m	$26.0 m
National Youth Sports Program	The purpose of this program is to motivate economically disadvantaged youth to earn and learn self-respect through participation in a program of sports instruction and competition. The program also provides counseling in alcohol and drug abuse prevention.	ACF	$10.6 m	$10.8 m	$12.0 m
NIDA Research Projects	As part of their research program, NIDA has conducted several studies involving pregnant substance abusers and their infants. Topics studied include: the effects of drugs on the fetus; the impact of prenatal cocaine, marijuana, alcohol and tobacco smoke exposure and its health consequences in pregnant women, newborns and developing children and; the extent and nature of drug use among pregnant women. In FY90, it is estimated that $46 million was spent specifically on maternal drug abuse research grants. Funding amounts shown are not specific to maternal drug abuse projects and include all drug abuse research projects, both intramural and extramural.	NIDA	$251.4 m	$297.2 m	$311.0 m

NIDA Surveys	NIDA has a number of surveys, including some specific to maternal substance abuse and their drug-exposed infants. Some of the surveys are: Drug Services Research Survey, In-Utero Drug-Exposure Survey, National Drug and Alcoholism Treatment Unit Survey (NDATUS), National Health Interview Survey (NHIS), National Health and Pregnancy Survey, National Household Survey on Drug Use, National Longitudinal Survey of the Labor and Market Experience, and the National Survey of Family Growth. The Drug Services Research Survey gathers data from a national sample of 1,000 treatment services on issues including the treatment of pregnant women and pregnancy status of clients. The In-Utero Drug Exposure Survey collects national estimates on the prevalence of substance use during pregnancy and the number of infants born exposed to drugs. The NDATUS collects facility-level data on all drug and alcohol treatment programs in the U.S. Beginning in 1991, the survey includes policy questions with regard to admitting pregnant women and the number and type of pregnant women in treatment. Also in 1991, NIDA included a supplemental questionnaire to the NHIS to obtain information about the prevalence of drug use during pregnancy The National Health and Pregnancy Survey provides national estimate n the prevalence of drug use in women delivering live infants in hospitals and the number of drug-exposed infants. The Household Survey gathers data on the prevalence of drug use. NIDA has included questions of the National Longitudinal Survey of the Labor Market Experience to determine the frequency of drug use during pregnancy by 1,400 women who have given birth since 1987. NIDA has also included questions on The National Survey of Family Growth Data to determine the prevalence of drug use during the last pregnancy from a sample of 10,000 women in their childbearing years. Data collection efforts are supported in part by a set-aside from the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant and from NIDA's research program.	NIDA	*	*	*
Preventive Health and Health Services Block Grant	This block grant provides states with funds for preventive health services not covered by categorical grants to reduce preventable morbidity and mortality and to improve the quality of life.	CDC	84.1 m	92.7 m	134.5 m

Primary Care Provider/Substance Abuse Linkage Initiative (SALI)	As part of the Comprehensive Community Treatment Program, this initiative provides a forum for primary care and substance abuse professionals to explore access to comprehensive medical services and is designed to strengthen the linkages between the primary health care and the alcohol, drug abuse and mental health treatment systems and to foster increased awareness of addiction and addiction-related disorders within the maintenance primary health care community. A special issues meeting on pregnant addicts and infants was held to identify barriers and recommend solutions to improve linkages. This first stage of this linkage ran from FY90 to FY92. The funding level given in FY90 reflects the total amount for the entire project period. Approximately 20 percent of the money was devoted specifically to women, pregnant women and babies exposed to crack cocaine.	OTI	$3.2 m	-	-
Primary Health Care and Substance Abuse Services for the Homeless	Grants are awarded to nonprofit agencies (public or private) to provide primary care health services and substance abuse services for the homeless. Beginning in FY92, special primary care, outreach and referral services for homeless children are provided.	BHCDA	$46.0 m	$39.0 m	$56.0 m
Projects for Assistance in Transition from Homelessness (PATH)	Formula grants are provided to states to provide a variety of social services to homeless persons who have mental health problems or mental health and substance abuse problems. This program replaced the Mental Health Services to the Homeless Block Grant Program administered by OTI.	NIMH	-	$33.0 m	$32.4 m
Social Services Block Grant Title XX	This block grant is the major source of Federal funding for social services programs in the states. The goals of the block grant are to (1) reduce or eliminate the economic dependency of the poor, (2) prevent neglect and abuse of children and adults who are unable to protect their own interests, (3) prevent or reduce unnecessary institutionalization and (4) secure institutional care when needed. Services that may be supported by this block grant include services designed for substance abusers such as detoxification, outpatient counseling and treatment. In FY 90, however, only eleven states indicated that they were providing substance abuse services with the block grant funds.	OTI	$2.8 b	$2.8 b	$2.8 b
Special Projects of Regional and National Significance (SPRANS)	These demonstration grants fund a variety of programs to improve maternal, infant and child health which may pertain to substance abusing women. Funding for these demonstration grants comes from the Maternal and Child Health Block Grant set-aside. Pregnant substance abusers are served in many of the projects. In FY 90, an estimated 7.6 million was spent on drug-exposed infants and their families.	MCHB	10-15% of MCH block grant	10-15% of MCH block grant	10-15% of MCH block grant

State Data Collection - Uniform Alcohol and Drug Abuse Data	Funds are provided to help support the enhancement of data collection capabilities at ate state level through adoption of national data standards. The adoption of uniform data is intended to result in an expanded epidemiological data base and improved care of persons with alcohol and other drug problems.	NIAAA	$6.0 m	$6.0 m	$6.0 m
Supplemental Security Income Program	This program provides income supports to elderly, blind and disabled individuals in low-income families, in foster care, or in institutions. Drug-exposure does not quality a child for benefits but drug-exposed children could receive benefits if their disabilities and family income and resources fall with program guidelines.	SSA	$12.6 b	$16.0 b	$19.8 b
University Affiliated Programs	A number of universities receive funding (1) to provide interdisciplinary training for persons concerned with developmental disabilities, (2) to disseminate information, (3) to demonstrate exemplary services and (4) to provide technical assistance. Several universities provide services to drug-exposed children.	ACF	$13.2 m	$14.0 m	$16.0 m
Urban Indian Alcohol and Substance Abuse Services	Alcohol and substance abuse prevention, education, treatment and rehabilitation services are provided through program and community-based services.	IHS	$2.5 m	$2.6 m	$2.7 m
Waiting Period Reduction Grant Program	This program is designed to expand treatment capacity in areas where patient demand exceeds availability of services. In FY90, priority was given to expanding existing treatment slots for pregnant and postpartum women or adding new treatment components for this population. This program is now defunct. It has been replaced by the Capacity Expansion Program.	OTI	$24.6 m	$38.5 m	$0
Washington D.C. Initiative	This treatment improvement initiative is part of the Comprehensive Community Treatment Program. Under this initiative, a diagnostic referral and evaluation unit, a residential treatment program and two outpatient treatment units provide comprehensive services including primary medical care, HIV/AIDS counseling and prevention, HIV testing, after care services, and prophylactic medications. IN FY91, 2.8 million was spent on the D.C. Initiative. The funding levels shown include all programs under the Comprehensive Community Treatment Program.	OTI NIDA	$6.6 m	$11.4 m	$11.9 m

* Funding information not available.

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
FUNDING SOURCES FOR COMPONENTS OF THE CHPR COMPREHENSIVE SERVICE DELIVERY MODEL

PROGRAM	DESCRIPTION	FUNDING SOURCE	FUNDING FY90	FY91	FY92
Community Development Block Grants	Block grants are provided to state and local governments to meet local community and economic development objectives including	HUD	*	$3.2 b	3.3 b
Comprehensive Improvement Assistance Program	This program provides assistance in modernization improvements, some of which may serve to prevent drug activity.	HUD	*	*	*
Housing Opportunities for Persons with AIDS	States, localities and nonprofit organizations receive grants to meet the housing needs of people with AIDS, include those who contracted the disease through substance abuse. Activities funded under this program include housing information and coordination of services, short-term supported housing or rental assistance, development and operation of community residences and services and the development of single-room occupancy dwellings.	HUD	-	-	$50.0 m
Neighborhood Development Demonstration Program	Funds are provides to neighborhoods organizations to implement community economic development activities. In 1992, this demonstration program ended but was replaced by a new program entitled the John Heinz Neighborhood Development Program	HUD	$2.0 m	$2.0 m	$2.0 m
Public Housing Child Care Demonstration Program	Demonstration grants are provided to nonprofit organizations to help establish child care centers for residents of public housing.	HUD	*	*	*
Public Housing Drug Elimination Program	Assistance is provided to public housing and indian housing authorities to establish plans for the reduction of drug-related crime. Activities may include drug abuse prevention, intervention referral and treatment programs.	HUD	$97.4 m	$150.0 m	$165.0 m
Shelter Plus Care Program	This programs provides rental and rehabilitation assistance to homeless persons with disabilities, primarily persons who have problems with drugs and/or alcohol, are HIV+, or are seriously mentally ill.	HUD	-	$0	$111.0 m

Youth Sports Clubs to Combat Drugs	This program seeks to establish youth sports clubs to combat drugs at public housing sites with severe drug problems. Recreational activities are offered as an alternative to drug use. This program receives 5 percent of the funds appropriated for the Public Housing Drug Elimination Program.	HUD	$4.9 m	$7.5 m	$8.2

* Funding information not available.

U.S. DEPARTMENT OF JUSTICE
FUNDING SOURCES FOR COMPONENTS OF THE CHPR COMPREHENSIVE SERVICE DELIVERY MODEL

PROGRAM	DESCRIPTION	FUNDING SOURCE	FUNDING FY90	FY91	FY92
Criminal Justice Formula Grants (Edward Byrne Memorial State and Local Government Formula Grant Assistance Program)	Provides funds to state and local law enforcement agencies to improve the functioning of the criminal justice system. States that apply for these funds are entitled to the greater of .25 percent of the total formula grant allocation or $500,000. Special emphasis is placed upon anti-drug enforcement efforts. Funds may be spent on drug treatment and prevention efforts.	BJA	$395 m	$423 m	$423 m
Criminal Justice Discretionary Grants	Provides funds to public and private non-profit organizations for demonstration, training and technical assistance projects. Special emphasis upon assisting states implement drug control efforts.	BJA	$50 m	$50 m	$50 m
Correctional Options Grant Program	Provides fund to public and non-profit private agencies to support projects that are alternatives to incarceration of offenders. Alternative programs may include substance abuse treatment and prevention while under correctional supervision.	BJA/NIC	-	-	$13 m
Juvenile Justice Formula Grant Program	Provides funds to state and local agencies to improve juvenile justice systems including drug treatment and prevention.	OJJDP	$50 m	$50 m	$50 m
Juvenile Justice Discretionary Grant Program	Provides funds to public and private non-profit agencies to support research, demonstration and technical assistance to prevent juvenile delinquency including drug treatment and prevention.	OJJDP	$20 m	$20 m	$20 m
Justice Research and Development Project Grants	Provides funds to public and private nonprofit agencies to support research, development and evaluation activities addressing crime and drug control. Specific program priorities change each year.	NIJ	$23 m	$24 m	$24 m
Criminal Justice Statistics Grant Program	Provides funds to public and private non-profit agencies to develop state level criminal justice statistics and information systems	BJS	$20 m	$22 m	$22 m
Improvement of Correctional Systems Grant Program	Provides funds to public and private (profit and non-profit) agencies to provide technical and financial assistance and training to development more effective, humane, constitutional and safe correctional systems at the prison, jail and community corrections levels.	NIC	$10 m	$10 m	$10 m

THE TOP 10 PRIVATE FOUNDATIONS FUNDING SOURCES FOR COMPONENTS OF THE CHPR COMPREHENSIVE ERVICES DELIVERY MODEL

FOUNDATION	AMOUNT	NUMBER OF GRANTS
1. The Robert Wood Johnson Foundation P.O. Box 2316 Princeton, NJ 08543-2316 609-452-8701	$3,205,161	16
2. The Ford Foundation 320 East 43rd Street New York, NY 10017 212-573-5000	$1,300,000	2
3. The Hall Family Foundation Post Office Box 419580 Kansas City, MO 64141-6580 816-274-8516	$1,200,000	1
4. The Meyer Memorial Trust 1515 S.W. Fifth Avenue, Suite 500 Portland, OR 97201 503-228-5512	$881,000	5
5. The David and Lucile Packard Foundation 300 Second Street, Suite 200 Los Altos, CA 94022 415-948-7658	$461,866	4
6. The Henry Kaiser Foundation Quadrus 2400 Sand Hill Road Menlo Park, CA 94025 415-854-9400	$398,967	1
7. The PEW Charitable Trusts Three Pkwy; Suite 501 Philadelphia, PA 19102-1305	$390,000	2
8. The Carnegie Corporation of New York 437 Madison Avenue New York, NY 10022 212-371-3200	$330,000	1
9. The Aaron Diamond Foundation, Inc. 1270 Avenue of Americas, Suite 2624 New York, NY 10020 212-757-7680	$290,067	1
10. The James Irvine Foundation 550 Kearny Foundation San Francisco, CA 94105 714-644-1362	$213,000	2
TOTAL	$8,670,061	35

PRIVATE FOUNDATIONS FUNDING SOURCES FOR COMPONENTS OF THE CHPR COMPREHENSIVE SERVICE DELIVERY MODEL
1990-1991

FOUNDATION	GRANTEE	GRANT DESCRIPTION	FUNDING
Altman Foundation 220 East 42nd Street Suite 411 New York, NY 10017 212-682-0970	Association to Benefit Children, NYC, NY	To develop special educational services for children exposed before birth to cocaine/crack.	$30,000
	Resources for Children with Special Needs, NYC, NY	To launch major projects addressing needs of infants & children exposed before birth to cocaine/crack.	$50,000
	Visiting Nurse Service of New York, NYC, NY	To launch First Steps, comprehensive case management program working with substance abusing mothers and their infants in Harlem.	$100,000
Claude Worington Benedum Foundation 1400 Benedum Trees Bldg. Pittsburgh, PA 15222 412-288-0360	West Virginia Department of Health & Human Resources, Charleston, WV	To study increase of substance abuse among West Virginia mothers.	$40,000
The Mary Owen Borden Memorial Foundation 160 Hodge Road Princeton, NJ 08540 609-924-3637	Epiphany House, Long Branch, NJ	For operating expenses of residential & treatment home for recovering women alcoholics and their children.	$10,000
Otto Bremer Foundation Suite 2000, 445 Minnesota Street St. Paul, MN 55101-2107 612-227-8036	Chrysalis Center for Women, Minneapolis, MN	For operating support for Chrysalis East which provides chemical dependency treatment and other services to low-income women.	$15,000
The Bush Foundation East 900 First National Bank Building 322 Minnesota St. St. Paul, MN 55101 612-227-0891	Minneapolis, City Of, Minneapolis, MN	For program to improve pregnancy outcomes for low-income women.	$69,990

	Sarah Family Programs, Saint Paul, MN	Toward a capital fund drive for a transitional housing program for chemically dependent women and their children.	$35,000
The Morris and Gwendolyn Cafritz Foundation 1825 K Street, N.W. 14th Floor Washington, D.C. 20036 202-223-3100	Marys Center for Maternal and Child Care, Washington, D.C.	To increase the number of women served by opening the clinic one evening a week and on weekends.	$30,000
	Saint Anns Infant and Maternity Home, Hyattsville, MD	For education program for pregnant adolescents and young mothers.	$20,000
	Washington Free Clinic, Washington, D.C.	To start pediatric care program and to expand prenatal clinic for low-income women who lack health insurance.	$40,000
The Carnegie Corporation of New York, NY 437 Madison Avenue New York, NY 10022 212-371-3200	University of Rochester, Rochester, NY	For a study of the Memphis New Mothers Project to determine if home visits to 400 low income mothers during and after pregnancy is effective in improving mother and infant health.	$330,000
Jessie B. Cox Charitable Trust c/o Grants Management Associates 230 Congress Street, 3rd Floor Boston, MA 02110 617-426-7172	Social Justice for Women, Boston, MA	Toward project, Catch the Hope, program which provides intensive health and other family support services to drug-addicted mothers involved in criminal justice system in Massachusetts.	$64,000
S.H. Cowell Foundation 260 California Street, Suite 501 San Francisco, CA 94111 415-397-0285	Catholic Charities of Archdiocese of San Francisco, San Francisco, CA	Toward start-up of Phoenix Project demonstration residential treatment program serving low-income, pregnancy, drug addicted women and their children.	$50,000
	Agency for Infant Development, Fremont, CA	For a project to prepare for drug-addicted babies.	$14,000
	National Council of Alcoholism, NYC, NY	For coalition on Alcohol and Drug Dependent Women & Their Children and for a hot line.	$75,000
Patrick & Anna M. Cudahy Fund P.O. Box 11978 Milwaukee, WI 53211 708-866-0760	Maryville City of Youth, Des Plains, IL	For care of newly born cocaine addicted babies.	$20,000

Aaron Diamond Foundation, Inc. 1270 Avenue of Americas, Suite 2624 New York, NY 10020 212-757-7680	Montefiore Medical Center, Bronx, NY	For a study of infants born to AIDS-infected mothers who are also intravenous drug users.	$290,067
The Duke Endowment 200 South Tryon Street, Suite 1100 Charlotte, NC 28202 704-376-0291	Self Memorial Hospital, Greenwood, SC	For comprehensive maternal and infant care service system for the medically indigent.	$100,000
Samuel S. Fels Fund 1616 Walnut Street, Suite 800 Philadelphia, PA 19103 215-731-9455	Philadelphia Parenting Associates, Philadelphia, PA	To provide technical assistance to staff working with formerly cocaine addicted mothers and their children.	$14,000
The Ford Foundation 320 East 43rd Street New York, NY 10017 212-573-5000	Center on Addiction and Substance Abuse, New York, NY	An eighteen month grant for a demonstration research program that will test comprehensive, community-based approaches to reducing drug abuse by high-risk populations.	$1 million
	Brigham & Women's Hospital, Boston, MA	A three year grant to study maternal-fetal policies related to AIDS, drug abuse and infant mortality programs and to develop integrated public policy agenda.	$300,000
General Mills Foundation P.O. Box 1113 Minneapolis, MN 55440 612-540-4662	University of Minnesota Foundation Institute for Disabilities Studies, Minneapolis, MN	For study on effects of cocaine use by pregnant women.	$100,000
George Gund Foundation 1845 Guildhall Bldg. 45 Prospect Avenue, West Cleveland, OH 44115 216-241-3114	Rainbow Babies & Children Hospitals, Cleveland, OH	For 2nd year of perinatal cocaine abuse project.	$125,000
Evelyn & Walter Haas, Jr. Fund One Lombard Street, Suite 305 San Francisco, CA 94111 415-398-4474	Catholic Charities of Archdiocese of San Francisco, San Francisco, CA	Toward Start-up of Phoenix Project demonstration residential treatment program serving low-income, pregnancy, drug-addicted women and their children.	$20,000

The Hall Family Foundation Post Office Box 419580 Kansas City, Missouri 64141-6580 816-274-8516	Truman Medical Center, Kansas City, MO	The grant is for the K.C. P.A.C.T. program for infants born to substance-abusing women. The program seeks to improve the chances of healthy outcomes of infants exposed to drugs and alcohol. It's main objective is to provide care, treatment and support to drug-dependent pregnant women in an effort to assure healthy births and drug-free environments.	$1.2 million
The Hearst Foundation 888 Seventh Avenue, 45th Floor New York, NY 10106-0057 212-586-5404	Catholic Charities of Archdiocese of San Francisco, San Francisco, CA	Toward start-up of Phoenix Project demonstration residential treatment program serving low-income, pregnancy, drug-addicted women and their children.	$35,000
Howard Heinz Endowment 30 CNG Tower 625 Liberty Avenue Pittsburgh, PA 15222-3115 412-391-5122	East End Cooperative Ministry, Pittsburgh, PA	Toward establishing the Sojourner House, a new residential center/halfway house for women recovering from drug & alcohol addiction and their children	$75,000
Hillman Foundation 2000 Grant Bldg. Pittsburgh, PA 15219 412-338-3466	East End Cooperation Ministry Pittsburgh, PA	Toward establishing the Sojourner House, a new residential center/halfway house for women recovering from drug & alcohol addiction and their children.	$35,000
Emma B. Howe Memorial Foundation A200 Foshay Tower 821 Marquette Avenue Minneapolis, MN 55402 612-339-7343	Chrysalis Center for Women, Minneapolis, MN	For start up support for child care program for children of women who are in chemical dependency treatment or aftercare.	$15,000
	Minnesota Indian Women Resource Center, Minneapolis, MN	For Nokomis Circle Program, which provides parenting skills to women recovering from chemical dependency.	$35,000
	University of Minnesota, Institute for Disabilities Studies, Minneapolis, MN	For pilot study of effects of prenatal cocaine exposure and learning in African-American infants.	$40,000
The Hyams Foundation One Boston Place, 32nd Floor Boston, MA 02108 617-720-2238	March of Dimes Birth Defects Fund, Boston, MA	For salary of project director for program to improve pregnancy and birth outcomes for substance abusing pregnant women.	$10,000

	Task Force on Children Out of School, Boston, MA	For phases one of project to analyze impact of substance abuse on Massachusetts children and their families.	$10,000
The James Irvine Foundation 550 Kearny Street, Suite 1715 San Francisco, CA 94105 714-644-1362	Paradise Valley Hospital, National City, CA	The grant is for the program, Healthy Beginnings, which is a perinatal substance abuse prevention program.	$153,000
	California Advocates for Pregnant Women, San Diego, CA	For network of health and social service professionals in the area of perinatal substance abuse.	$60,000
The J.M. Foundation 60 East 42nd Street, Room 1651 New York, NY 10165 212-687-7735	March of Dimes Birth Defects Foundation, New York, NY	To initiate the OB/GYN and Pediatric Residency Training Program in the Identification and Treatment of Women with Chemical Dependency.	$25,000
	Women's Action Alliance, New York, NY	To disseminate an Alcohol and Drug Education Guide concerning disadvantaged, minority, and low-income women and advance program replication nationwide	$10,000
The Robert Wood Johnson Foundation P.O. Box 2316 Princeton, NJ 08543-2316 609-452-8701	Maternity Center Association, New York, NY	For the planning of collaborative maternity care services for low income women.	$278,255
	Medcofund, Inc., New York, NY	For a physician-led managed care program for underserved women and children.	$199,969
	University of Iowa, Iowa City, IA	For evaluation of barriers to obtaining prenatal care for Iowa women.	$196,112
	Hahnemann University, Philadelphia, PA	For a dissemination of a model foster care program for drug-addicted infants.	$45,309
	Prison Match, Berkeley, CA	For addiction services for inmates and their families.	$49,998

	Research Foundation of the City University of New York-Hunter College, New York, NY	Reducing substance abuse and infectious disease among jail inmates.	$992,337
	Brigham and Women's Hospital, Inc., Boston, MA	To address conflicts in maternal-child health policy.	$413,592
	Community Medical Alliance, Boston, MA	Planning for program to aid community substance abuse initiatives.	$44,808
	Economic Opportunity Family Health Center, Inc., Miami, FL	Financing model for residential treatment for pregnant addicts.	$198,492
	George Washington University, Center For Health Policy Research, Washington, D.C.	Analysis of resources to aid drug-exposed infants and their families.	$228,354
	Office of the District Attorney, Kings County, Brooklyn, NY	Assessment of drug treatment alternative to prosecution.	$50,000
	Yale University, School of medicine, New Haven, CT	Prospective study of infants born to cocaine-abusing mothers	$110,098
	The Center on Addiction and Substance Abuse, New York, NY	Planning support for the Center on Addiction and Substance Abuse.	$50,000
	Fighting Back Program: The Greater Kansas City Community Foundation, Kansas City, MO	Designed to help community coalitions reduce the demand for illegal drugs and alcohol through a continuum of coordinated services from prevention to treatment.	$50,000
	Fighting Back Program: Marshall Heights Community Development Organization, Washington, D.C.	Designed to help community coalitions reduce the demand for illegal drugs and alcohol through a continuum of coordinated services from prevention to treatment.	$50,000

	Confederated Tribes and Bonds of the Yakima Indian Nation Reservation, Toppenish, WA	For fetal alcohol syndrome prevention program.	$247,837
Henry J. Kaiser Foundation Quadrus 2400 Sand Hill Road Menlo Park, CA 94025 415-854-9400	Pierce County Alliance, Tacoma WA	To conduct and evaluate delivery of family planning and obstetrical services for substance-abusing women.	$398,967
Knight Foundation One Biscayne Tower, Suite 3800 Two South Biscayne Blvd Miami, FL 33131-1803 305-539-0009	Edwin Shaw Hospital Development Foundation, Akron, OH	To renovate and furnish residential treatment center for women addicted to cocaine.	$15,000
	Florence Crittenton Services, Charlotte, NC	For capital campaign to renovate substance abuse treatment facility for pregnant girls and children.	$25,000
Faye McBeath Foundation 1020 North Broadway Milwaukee, WI 53202 414-272-2626	Children's Hospital of Wisconsin, Milwaukee, WI	Toward research in behavioral and neurological effects of cocaine on babies who are exposed prior to birth.	$70,000
Kornet Foundation 33 New Montgomery Street Suite 1090 San Francisco, CA 94105-4509	Catholic Charities of San Francisco, CA	Toward start-up of Phoenix Project demonstration residential treatment program serving low-income, pregnancy, drug-addicted women and their children.	$50,000
Meyer Memorial Trust 1515 S.W. Fifth Avenue, Suite 500 Portland, OR 97201 503-228-5512	Healthy Start, Hillsoro, OR	A grant for a community-based prenatal and maternity care program for low-income women in Washington County.	$240,000
	Sacred Heart Medical Center, Eugene, OR	A grant to expand a nurse-midwife prenatal clinic for low-income that will encourage them to obtain care early in their pregnancies.	$136,000
	Southwest District Health Department, Caldwell, ID	For a program of extensive services to pregnant and parenting teenagers in six rural counties, including prenatal and postpartum care, parenting education, nutrition counseling, child care, employment training, family planning and education.	$225,000

	St. Charles Medical Center, Bend, OR	For Healthy Start, a prenatal service for low income women.	$60,000
	Virginia Garcia Memorial Center, Cornelius, OR	For the Positive Parenting Initiative project, which provides parenting education and support for Hispanic low-income women and teen-age parents, beginning with their participation in a prenatal care program.	$220,000
Eugene & Agnes E. Meyer Foundation 1400 16th Street, N.W. Suite 360 Washington, D.C. 20036	Associated Catholic Charities, Washington, D.C.	For St. Martin's House program to aid homeless women with histories of drug abuse and their high risk infants and young children.	$15,000
	March of Dimes Birth Defects Foundation, Arlington, VA	For Healthy Babies Project to reduce low birthweight, infant mortality and morbidity rates among infants of pregnant substance abusing women in Ward 5.	$30,000
New York Community Trust Two Park Avenue, 24th Floor New York, NY 10016 212-686-0010	Beth Israel Medical Center, NYC, NY	For model substance abuse treatment program for women with children living in family shelters.	$50,000
	NARCO Freedom, Bronx, NY	To include preventive services in treatment program for crack-addicted women with children.	$50,000
	New York Society for Prevention of Cruelty to Children, NYC, NY	To prepare child and health care workers to address treatment issues faced by drug-exposed infants/families.	$10,000
The David and Lucile Packard Foundation 300 Second Street, Suite 200 Los Altos, CA 94022 415-948-7658	National Bureau of Economic Research, New York, NY	Cost-benefit analysis of prenatal treatment for maternal substance abuse.	$120,066
	Natividad Medical Center, Salinas, CA	To develop a plan to increase access to prenatal care.	$10,000
	Salud Para La Gente, Watsonville, CA	To initiate a comprehensive perinatal service program.	$126,800
	Stanford University, Stanford, CA	For a perinatal community outreach program.	$205,000

The PEW Charitable Trusts Three Pkwy; Suite 501 Philadelphia, PA 19102-1305 215-568-3330	The Johns Hopkins University, Baltimore, MD	For the Johns Hopkins Program for Medical Technology and Practice Assessment, School of Medicine. In support of a survey of Medicaid-eligible women and their access to prenatal care services.	$155,000
	National Public Health and Hospital Institute, Washington, D.C.	For a national survey of models developed by public hospitals and community organizations to respond to the crisis of cocaine-involved infants.	$235,000
The Pittsburgh Foundation 30 CNG Tower 625 Liberty Avenue Pittsburgh, PA 1522-3115 412-391-5122	East End Cooperative Ministry, Pittsburgh, PA	Toward establishing the Sojourner House, a new residential halfway house for women recovering from drug & alcohol addiction and their children.	$35,000
Public Welfare Foundation, Inc. 2600 Virginia Avenue, N.W. Room 505 Washington, D.C. 20037-1977 202-965-1800	Community of Hope, Washington, D.C.	For continued support for Maternal-Infant Support & Recovery Program offering health & rehabilitative services to drug-abusing mothers and pregnant women, health services to drug-exposed infants and children and drug prevention education to adolescents in the community.	$40,000
	Crossroads, New Haven, CT	For expansion of women's drug treatment program to include assertiveness training directed toward prevention of relapse and promotion of assertiveness in sexual relationships as a deterrent to contracting HIV/AIDS.	$25,000
Kate B. Reynolds Charitable Trust 2422 Reynolds Road Winston-Salem, NC 27106-4606 919-723-1456	Bethany House, Southern Pines, NC	To renovate facility for female substance abusers.	$20,000
	Christian Rehabilitation Center, Charlotte, NC	For start up expenses of residential facility for female substance abusers.	$164,890
Z Smith Reynolds Foundation, Inc 101 Reynolds Village Winston-Salem, N.C. 27106-5199 919-725-7541	Hope Harbor Home, Supply, NC	For substance abuse counselor/transition counselor for clients of shelter for abused women and children.	$10,000

San Diego Community Foundation Wells Fargo Bank Building 101 West Broadway, Suite 1120 San Diego, CA 92101 619-239-8815	Escondido Youth Encounter, Escondido, CA	For equipment for Options for Recovery program for drug addicted mothers and children.	$15,775
San Francisco Foundation 685 Market Street, Suite 910 San Francisco, CA 94105-9716 415-495-3100	Catholic Charities of the Archdiocese of San Francisco, San Francisco, CA	For start-up assistance for San Francisco Phoenix Project, model residential treatment program for pregnant crack addicted women and their children.	$25,000
Seattle Foundation 425 Pike Street, Suite 510 Seattle, WA 98101 206-622-2294	University of Washington, Seattle, WA	For Fetal Alcohol Syndrome Research program.	$17,640
The Sierra Foundation 11211 Gold County Blvd., Suite 101 Rancho Cordova, CA 95670 916-635-4755	Chemical Dependency Center for Women, Sacramento, CA	To provide AIDS education program for women in county jails and to assess effect of education on women's drug use patterns and contraception practices.	$60,000
	Enloe Hospital Foundation, Chico, CA	To implement Volunteer Outreach and Mentoring project to supplement Perinatal Substance Abuse Project.	$32,633
	Saint Elizabeth's Community Hospital, Red Bluff, CA	To provide outpatient substance abuse counseling to pregnant women and training in recognition and management of perinatal substance abuse for providers.	$27,491
	The Center for Community Health and Well-Being	To support the administration of the Birthing Project, a mentoring program for high-risk, low-income pregnant women.	$30,000
	University of California, Davis, CA	To provide matching funds to establish project that offers continuum of care services to pregnant substance-abusing women.	$25,000

The Christopher D. Smithers Foundation, Inc. P.O. Box 67 Oyster Bay Road Mill Neck, NY 11765 516-676-0067	Gratitude House, West Palm Beach, FL	A grant for the Gratitude House that helps women recover from addictions since 1968. In 1991, 350 women were helped at the Gratitude House. The services received over a three month period included individual and group therapy, through grounding in 12-step programs for continuing recovery and specialized individual treatment.	$15,000
	Wayside House, Delray Beach, FL	Wayside House is a residential treatment and rehabilitation center for women founded in 1974. This program is to help women released from prison where they served time for alcohol and other drug related crimes.	$10,000
Victoria Foundation, Inc. 40 South Fullerton Avenue Montclair, NJ 07042 201-783-4450	Choices, Newark, NJ	For operational costs as well as for improved program supervision for substance-addicted mothers and their children.	$40,000
The Zellerbach Family Fund 120 Montgomery Street, Suite 2125 San Francisco, CA 94104 415-421-2629	Solid Foundation, Oakland, CA	A grant for Mandela House for family maintenance and reunification healthy child development and community outreach program for drug-addicted mothers and their infants in collaboration with the Alameda County Drug & Alcohol Services	$57,500
	Film Arts Foundation, San Francisco, CA	A grant to produce the video, Season of Hope about mothers of drug-exposed infants.	$37,000
TOTAL:			$10,984,980

APPENDIX F:

SAMHSA

The Substance Abuse and Mental Health Services Administration

Block Grant For The Prevention And Treatment Of Substance Abuse

Priority Placement and Set-Aside for Pregnant Women

According to the 1992 Reorganization Law, states must give preference to pregnant women who seek treatment or who are referred for treatment. If a treatment bed is not available, the state must provide interim services. States are required to publicize the availability of preferential services for women, and treatment and prevention services are required to provide continuing education for their personnel. The state must also coordinate prevention and treatment activities with other services including health, social, corrections and criminal justice, education, vocational rehabilitation and employment.

Utilization of Block Grant Funds for Pregnant Women

It is difficult to determine the exact amount of block grant money being used for substance abusing pregnant women and their children. Currently, there is no data on the amount of money each state receives or the amount of money spent on substance abusing women and their children or the number of women served. A major barrier to assessing how block grant is the variation in the procedure within the states. Each state has a single state authority that receives the federal block grant money which is distributed according to legislation and allocation by that state government.

Lack of Data

Currently, Congress does not have information to determine the effectiveness of the set-aside for increasing appropriate treatment for substance abusing women and their children. One reason for the lack of data and information is that the Department of Health and Human Services (HHS) has not exercised its authority to clearly specify to the states what information must be reported. Many states' reports do not include the drug treatment programs that serve women and children or identify new or expanded treatment programs even though it is required by the 1988 Anti-Drug Abuse Act.

In 1991, the General Accounting Office (GAO) reviewed the annual ADAMHA reports for FY89, and found that all the states used 10 percent of the block grant for treatment of women. For many states however, the GAO could not determine if the women's set-aside was used to develop programs and services specifically designed for women, including women alone, pregnant women or women with children. They were also unable to determine if programs for both men and women were being counted toward the women's set-aside.

The Office of Inspector General (IG) (1991) conducted a survey of 125 ADMS substance abuse block grantees in 10 states and reported consistent findings: 1. About one-half of the agencies serve pregnant addicts. 2. Pregnant addicts represent an extremely small portion of the total client population of these agencies. Seventeen percent could not provide an estimate; 37 estimated less than 1 percent; and 16 percent reported pregnant addicts represent more than 5 percent of their population. 3. Pregnant addicts receive the same services as other clients rather than services developed specifically for them (DHHS, Office of the Inspector General, 1991).

In general states lack accurate data on the numbers of pregnant addicts in their state and the providers who service them. Every state has a different format for reporting, and because of

the variability, it is impossible to aggregate the data and analyze treatment needs of pregnant women or to determine how the women's set-aside in each state is used. In some states an individual grantee may receive funding without knowing the exact source of that money.

The GAO (1991) recommended that federal agencies specify annual reporting requirements so that the data can be aggregated and standardized to delineate a clearer picture of the treatment programs for women and their children. Specifically states are recommended to gather information on all the treatment programs available for women and women with children including new or expanded programs designed for women, pregnant women or women with children. The states are also recommended to determine the number of drug-abusing pregnant women and women and children within their domains (DHHS, GAO, 1991).

As a result, the '92 ADMS block grant application has specific questions regarding programs for pregnant women and their children including how the state defines women in need of services, how the state spends its money in compliance with the block grant funds, what improvements the state has made for women,and how the state monitors and collects data concerning women who are treated. Until that information is collected and analyzed, it will be impossible to determine the outcome of the set-aside for women with the block grant program.

APPENDIX G:

PREGNANT AND POSTPARTUM WOMEN AND THEIR INFANTS PROGRAM (PPWI)

SAMHSA

According to the 1991 Pregnant and Postpartum Women and their Infants (PPWI) program announcement and grant application, proposed activities should be consistent with coordination of existing services, outreach for the provision of services, financial and other incentives that increase the accessibility and acceptance of services, augmentation of existing services and creation of new comprehensive services. Examples of fundable activities include:

Primary prevention:

- information and education on alcohol and other drug use at the point of family planning
- forms of public education concerning the risks of alcohol and drug use during pregnancy linked to other programmatic efforts

Intervention with pregnant and postpartum women:

- routine implementation of effective screening of pregnant women for past and present alcohol use and other drug use and for co-occurring mental disorders
- innovative methods of outreach to identify and recruit the target populations for services, preferably in the early stages of pregnancy
- integration and coordination of alcohol and other drug treatment with prenatal and postpartum health care
- psychological and emotional support for pregnant and/or postpartum alcohol and drug using women
- education and skill-building designed to increase the likelihood of positive familial and social functioning (e.g., parenting skills, job-seeking skills)
- support services (e.g., childcare, transportation) to facilitate women's use of other services
- advocacy for the assurance of care

Infant-Oriented Interventions:

- direct intervention/treatment/rehabilitation with infants in order to reduce the impact of maternal substance use

- informational, emotional support and resources for biological, foster parents or other guardians of infants affected by maternal substance use(follow-up services)

Service Delivery Strategies:

- coordination-for purposes of identification and service delivery-with other likely points of access for vulnerable women(e.g., shelters, AFDC, WIC programs, crisis pregnancy centers, public housing, centers for battered women, Head Start centers, jails, AIDS/HIV prevention programs)

- innovative, integrated services for pregnant and postpartum women with co-occurring mental and substance abuse disorders

- involvement of significant others as direct intervention targets or as resources for aiding in the outreach and service delivery processes for women

- co-location or multiple locations (e.g. satellite centers, extension services, "one-stop shopping") to increase client access to services and to facilitate service delivery

- innovative strategies(e.g. case management) to ensure the coordinated utilization of generally unrelated service systems

- targeted services to prevent recurrence of substance-abusing behavior

- other services to eliminate barriers to service that would increase the time a client stays in treatment

Personnel Strategies:

- inter-organizational personnel exchange for the creation of interdisciplinary teams within service settings

- expanded roles for professionals and other caregivers in encouraging the development of comprehensive services systems

- continuing education of providers regarding the needs and intervention strategies appropriate for the target populations

- utilization of trained caregivers recruited from the community(natural helpers)

- educational programs for primary care providers to improve recognition and referral of pregnant and postpartum women with co-occurring mental and substance abuse disorders

The goals of the PPWI program are:

- promote the involvement and coordinate participation of multiple organizations in the delivery of comprehensive services for substance using pregnant and postpartum women and their children,
- increase the availability and accessibility of prevention, early intervention and treatment services for these populations,
- decrease the incidence and prevalence of drug and alcohol use among pregnant and postpartum women,
- improve the birth outcomes of women who use alcohol and other drugs during pregnancy and to decrease the incidence of infants affected by maternal substance abuse,
- reduce the severity of impairment among children born to substance using women.

Applicants for PPWI must meet eligibility criteria for Medicaid and Title XIX funds. Applicants must provide an appropriate outreach program and be accessible to low income pregnant and postpartum women. Services must be language and culturally specific, and staff must receive continuing education. Each grant award is to be funded for at least three years, but not to exceed five years.

CSAT is mandated to collaborate with CSAP funded projects on outreach services, especially for pregnant and postpartum women and their children. CSAP will continue to manage the existing grants for PPWI until these projects are completed. There are new requirements for PPWI grantees under the reorganization, but the programs already in progress can complete their grant as originally awarded. CSAT will administer all the new grant awards.

APPENDIX H:

MODEL PROJECTS FOR PREGNANT AND POSTPARTUM WOMEN AND THEIR INFANTS PROGRAM

The following are current operating demonstration projects under PPWI:

Born Free: Perinatal Substance Abuse Intervention and Recovery Model
Martinez, CA
The primary goal of this project is to decrease the prevalence of substance abuse among pregnant women and new mothers and to increase the number of intact, recovering families. The Born Free program introduces a new substance abuse screening tool which draws on concepts of family codependency to identify substance abusers at the time of labor and delivery. The project incorporates the doula model, in which the mother is provided a companion for psychosocial support during labor and delivery, into a new model in which the birth companion is herself a recovering woman who provides support both in the critical weeks before and after the birth of the baby. The program incorporates substance abuse counselors into interventions by Child Protective Services(CPS) and thereby provides additional impetus for the mother to participate in recovery activities. This intervention model seeks to incorporate the entire family into a recovery program.

The Born Free project draws on the services created in Contra Costa County under the auspices of the Healthy Start Program and the Born Free pilot program. Healthy Start is a joint program of the Public Health Division and the Hospital and Clinics Division of the Health Services Department. It was established in 1988 in response to State legislation which created a reimbursement mechanism for the provision of multidisciplinary prenatal services for the Medi-Cal (Medicaid) population. These services include obstetric, nutritional psychosocial and health education.

Perinatal Substance Abuse Prevention Project
Logan Heights Family Health Center
San Diego, CA
The overall goal of the project is to decrease the incidence and prevalence of alcohol and drug abuse among pregnant and postpartum women within the health center service area, thereby improving birth outcomes and reducing the incidence of infants affected by maternal substance abuse. Program objectives fall under five major categories of activities: 1) Outreach and Education 2) Screening and Identification 3) Case Management 4)Counseling and Support 5) Training.

Model Projects for Pregnant and Postpartum Women and Their Infants
University of South Florida
College of Public Health
Tampa, FL
The projects goals and objectives are to improve birth outcomes in high-risk census tracts through reducing substance use in pregnancy and strengthening linkages among prenatal care service, high-risk pregnancy services, and substance abuse treatment programs. Neighborhood-based community health aides and social service coordinators work to secure day care and transportation services to help clients get to clinic and substance abuse treatment. A coordinator trains participating agencies to identify, refer and treat substance-abusing pregnant women and train the community health aides.

Prevention of Substance Abuse by Pregnant and Postpartum Women
Shands Hospital
Department of Social Work Services
Gainsville, FL
The goals and objectives are to promote the involvement and coordinated participation of multiple organizations in the delivery of comprehensive services; increase the availability and accessibility of prevention, early intervention and treatment services; decrease the incidence and prevalence of drug and alcohol abuse; improve birth outcomes; and reduce the severity of impairment among children born to substance-abusing women. Case management or service coordination is used to facilitate prenatal care and post-delivery program compliance. Clients are screened using a self-assessment tool to identify women who are at high risk for or currently abuse drugs and alcohol. Identified clients are then voluntarily enrolled in the program. The case managers provide individual and group clinical intervention at prenatal visits and monitor compliance and progress with clients.

Project K-MOD(Keeping Mothers Off Drugs)
Apalachee Center for Human Services, Inc.
Tallahassee, FL
Project K-MOD (Keeping Mothers Off Drugs) is located within the Chemical Dependency Unit of Apalachee Center for Human Services. The project links together country health units; economic aid services; Children, Youth and Families services; and expands substance abuse treatment availability. In addition, the project provides needed transportation and child care supervision for those mothers within the target population who have neither.

Comprehensive Intervention for Recovering Addict Mothers
Emory University School of Medicine
Human and Behavioral Genetics Research Laboratory
Georgia Mental Health Institute
Atlanta, GA
The aim of the Georgia Addiction, Pregnancy, and Parenting Project (GAPP) is to reduce the

incidence of problems associated with prenatal drug exposure and postpartum drug use by (1)increasing the number of women who are able to discontinue drug use during pregnancy through community outreach, education and intervention; and (2) facilitating continued abstinence postpartum through case management; psychosocial support; training in interpersonal, coping, and job-seeking skills; parenting education; and instrumental support to women who are motivated to discontinue their use of drugs. The comprehensive intervention program includes the development, implementation and evaluation of an aftercare program for women of childbearing age who have completed drug treatment in State-funded alcohol and drug treatment facilities, public health clinics and other nonprofit organizations who provide space, housing, staff support, transportation and child care for women participating in the GAPP program.

Pineland Mental Health, Mental Retardation, and Substance Abuse Services
Bulloch County Board of Health
Pineland Mental Health, Mental Retardation and Substance Abuse
Statesboro, GA
The program goals and objectives are to provide appropriate training to staff of human services agencies dealing with pregnant women; develop a model program of intervention for selected pregnant women who are identified as substance abusers; and provide a 2-year follow-up of the women and infants served by this program to assess the impact of the program on the development of the child and on the lifestyle of the mother. Training of human providers for early identification of eligible patients and coordination of services and long-term supervised living arrangements that exhibit aspects of a therapeutic community allow eligible women to remain safe and drug free while they establish a strong foundation for sobriety and acquire skills needed for parenting and supporting themselves.

IPCA Perinatal Care Project for Substance Use Prevention
Idaho Primary Care Association
Boise, ID
The goals and objectives of the program are: 1)decrease the use of nicotine, alcohol, and other drugs among pregnant and postpartum women, 2)improve the birth outcomes of women who used alcohol and other drugs during pregnancy, 3)increase the availability and accessibility of prevention and early intervention services for substance-using pregnant and postpartum women and other women in the childbearing years who are at high risk, particularly low-income and minority women and 4) promote the coordinated participation of multiple organizations in the delivery of comprehensive services for substance-using pregnant and postpartum women and infants. The model links primary medical care resources--community and migrant health centers--with the State's substance abuse treatment facilities and other community support services. The services include free pregnancy tests and referral of WIC and family planning clients to C/MHCs for screening and treatment. A key element of this project is that the primary care provider becomes an integral part of the case management process.

Improving Pregnancy Outcomes of Substance-Abusing Mothers
Coalition on Addiction, Pregnancy, and Parenting of the Massachusetts Health Research Institute, Inc.
Cambridge, MA
The goals and objectives of this program are 1) to promote the involvement and coordinated participation of multiple organizations in the delivery of comprehensive services for substance-using pregnant and postpartum women and their infants, 2) to increase the availability of prevention, early intervention and treatment services for these populations, 3) to decrease the incidence and prevalence of drug and alcohol use among pregnant and postpartum women, 4) to improve the birth outcomes of women who used alcohol and other drugs during pregnancy and to decrease the incidence of infants affected by maternal substance abuse, 5) to reduce the severity of impairment among children born to substance-using women. Five diverse agencies are collaborating on this project: The Women's Alcoholism Program of CASPAR, Inc.'s residential program for addicted women and their newborns (New Day); Women Inc's residential program for pregnant addicted women and their children; Health and Addictions Research, Inc.; the Fetal Alcohol Education Program of the Boston University School of Medicine; and the Boston Children's Hospital. The project has three major activities: a service demonstration component, an access to treatment component and a policy and planning component.

Mother and Infant Substance Abuse Network
Detroit Health Department
Detroit, MI
The overall goal of this project is to reduce infant mortality in the city of Detroit. This will be accomplished by providing a continuum of care to coordinate maternal and infant care with substance abuse treatment for 250 substance-abusing pregnant women. The Detroit Health Department promotes the involvement and coordinates the participation of multiple organizations in the delivery of comprehensive services for substance-using pregnant and postpartum women and their infants. Annually, a maximum of 250 pregnant, substance-abusing women and their infants are referred through a referral network to the Eleanor Hutzel Recovery Center (EHRC) for treatment. The facility, unique in Detroit, combines drug treatment and prenatal care in one facility. Major services provided include: high risk prenatal/postpartum care; preparation for baby and support for drug abstinence; individual counseling; methadone maintenance; group programs including prepared childbirth, parenting, AIDS risk reduction, nutrition and self-esteem; and detoxification from methadone after delivery. The Detroit Health Department assumes case management and coordinates care so that EHRC women receive all maternal and child health services provided by public health, including but not limited to the following:1) paraprofessional Outreach Program 2) public health nursing 3) maternal support services 4)children with special health care needs services.

Perinatal Substance Abuse Prevention Program
Model Cities Health Center, Inc.
St. Paul, MN 55103
The goals and objectives of the program are:1) to improve birth outcomes among chemically

dependent and chemically abusing females residing in the service area and 2)to promote healthy parent-child relationships in chemically exposed families. Community education, outreach and development of culturally sensitive materials are provided on a community wide basis. Group sessions for women of childbearing age are conducted to address the medical aspects of chemical dependency, as well as feelings of guilt, shame and denial. Transportation and child care services are provided, one-to-one counseling is scheduled for all high-risk pregnant women, and Brazelton and Bayley developmental tests are performed on cocaine-exposed infants. Parenting education and support occurs during regularly scheduled visits.

Comprehensive Perinatal Program for Pregnant Drug Users
University of New Mexico School of Medicine
Department of Obstetrics and Gynecology
Albuquerque, NM
The goal of this project is to create a well organized core perinatal program for pregnant substance abusers by coordinating individual service agencies. The methodology of the program is the following: 1) to develop a system to coordinate individual service agencies throughout the duration of the project to maximize delivery of services to pregnant substance abusers, 2)to develop a comprehensive substance abuse treatment program for the patient, 3) to maximize the best maternal care possible for the addicted infant and 4)to promote, support and educate addicted mothers in developing a healthy attachment bond and positive parenting style with difficult, at-risk infants.

Maternity, Infant Care-Treatment Intervention Program for Pregnant and Postpartum Women and their Infants (MIC-TIP)
Medical and Health Research Association of New York City, Inc.
New York, NY
The goals of this project are to reduce substance abuse, improve birth outcomes and reduce the extent to which infants are affected by maternal substance use in a group of maternity patients by developing a comprehensive, case-managed approach utilizing already existing community resources and encouraging the development of new ones in three New York City prenatal clinics.

Women and Infants
New York City Department of Health
Bureau of Maternity Services and Family Planning
New York, NY
This project has two primary goals: 1)to promote the involvement and coordinated participation of multiple organizations in the delivery of comprehensive services for substance-using pregnant and postpartum women and their infants and 2)to improve the birth outcomes and reduce the severity of impairment among children born to substance-using women through increased availability and access to drug treatment, preventive health services, parenting education, and social support services.

Women's and Infant's Substance Abuse Program
Robeson Health Care Corporation
Pembroke, NC
The goals for the perinatal and postpartum demonstration project are to show how services can be delivered in the context of primary health care practices that include enhanced perinatal health care services.

Hope For Families
St. Vincent Medical Center
Department of Pediatrics
Toledo, OH
The goals and objectives of Hope for Families are 1) to involve the community in preventing substance use during pregnancy, 2)to decrease substance use in pregnancy through identification and engagement of pregnant substance users in individualized, family-focused early intervention and 3)to reduce the consequences of substance abuse in pregnancy.
Primary prevention is achieved through early identification of the problem with toxicology screening. Tertiary prevention minimizes the consequences of substance use through aggressive intervention.

Coordinated Care System for Substance-Abusing Pregnant Women
Multnomah County Office of Women's Transition Services
Portland, OR
The goals and objectives of the ADAPT program include: 1)improved health status of infants born to female offenders, 2) involvement in alcohol and drug treatment services and prenatal care for female offenders, 3)elimination of substance abuse during pregnancy in this population. The methodology of the ADAPT Program is a community-based, outreach-oriented, multidisciplinary services model for pregnant and postpartum women and their children. Prenatal care and substance abuse treatment services occur in Multnomah County jail once women are identified as being pregnant and having a history of substance abuse. Community health nurses and substance abuse counselors visit the jail weekly and plan follow up care for women who are not jailed for the duration of their pregnancy. Upon release from jail, the women participate in intensive group substance abuse treatment 4 days per week, 3 hours per day for 65 weeks, with ongoing substance abuse treatment for the remainder of the pregnancy.

Project Network: A Model of Coordinated, Managed Care
Emanuel Hospital and Health Center
Portland, OR
The primary goal of this project is to increase the availability and accessibility of prenatal care and drug treatment. A second project goal is to provide long-term support and education for the family. The third project goal is to promote involvement and integration of community services and resources. Project Network's community resource staff play a vital role in helping to achieve the project's goals and objectives. They assist women in keeping their prenatal

appointments and attending the drug treatment program by providing transportation and providing child care at the hospital. This community staff provides "flex-time", a period of time when a client may choose what help she needs (e.g., a ride to the bank or laundromat, or child care).

Targeted Adolescent Pregnancy Substance Abuse Report
University of Washington Medical Center
Social Work Department RC-30
Seattle, WA
This project has two primary goals:1)to prevent or decrease drug use among high-risk adolescents who are pregnant and 2)to decrease the likelihood of multigenerational cycles of drug use. The methodology for the project includes:1)Behavioral skills training which is based on the Project ADAPT model, a community transition program for juvenile delinquents funded through the National Institute of Drug Abuse. The training are conducted prenatally for 9 weeks, with one session each week which includes an incentive program. Financial assistance, transportation and/or child care are made available to participants. 2)Parenting education occurs both prenatally and postpartum. 3)The participants are assigned to a social worker and a public health nurse who provide joint case management services. 4)In order to enhance the participant's success in the project, two orientation sessions are held for people in the participant's support network.

Rural South Central Wisconsin Perinatal Addiction
University of Wisconsin at Madison
Lowell Hall
Madison, WI
The project establishes partnership among the University of Wisconsin (with its wide array of different services, training, and research programs), the perinatal centers (with their clinical services), the primary care providers (in the predominantly rural community), and community-based prevention, intervention and treatment programs. The project builds upon the strengths of the existing service system. Gaps and needs are identified as this integration occurs, and programs are developed to address these gaps and needs.

APPENDIX I:

NIDA PERINATAL 20

The NIDA Perinatal 20 Research Demonstration Program was developed to evaluate the effectiveness of 21 comprehensive therapeutic programs designed to treat drug abusing women of childbearing age and their children. The following treatment characteristics are the variables to be evaluated:

1. FACILITY OR PHYSICAL ENVIRONMENT
   place where treatment takes place
   i.e., outpatient clinic, community-based social service agency

2. THERAPEUTIC APPROACHES
   detoxification, individual counseling, sexual issues therapy,
   i.e., mother-child interactive play

3. SUPPORTIVE SERVICES
   i.e., child care, transportation

4. STAFFING CHARACTERISTICS
   i.e., professional training and certification
   racial and gender makeup, caseload, number of client - patient contact hours

5. TIME IN TREATMENT

6. PROGRAM MANAGEMENT CHARACTERISTICS
   i.e., outreach, referral, admission, discharge procedures,
   type of case management

Outcome variables include:

1. SERVICE UTILIZATION

2. USE OF ALCOHOL AND OTHER DRUGS

3. EMPLOYABILITY STATUS

4. CRIMINAL BEHAVIOR

5. FAMILY RELATIONSHIPS

6. PARENTING SKILLS

Examples of grantees under the NIDA Research Demonstration Program include:

NIDA PERINATAL 20 GRANTEES

Purdue University Family Research Institute / Terros, Inc.
Lafayette, Indiana / Phoenix, AZ
Couple-Focused Therapy
Non-hospital based neighborhood clinic
Longitudinal study of 180 randomly assigned drug abusing women with partners compares the effectiveness of three outpatient treatment conditions over 3, 6, and 12 month intervals.

Amity, Inc.
Tucson, AZ
Non-medically based residential Therapeutic Community (TC)
Longitudinal study of 35 randomly assigned women compares the effectiveness of 18 month therapeutic community treatment when women are allowed to have their children in residence vs. the standard TC treatment women without having children in residence.

University of Southern California, Los Angeles
Los Angeles, CA
Hospital-based outpatient clinic and a non-hospital based neighborhood clinic
Longitudinal study of 200 randomly assigned pregnant substance-abusing adult women and their children are recruited during the prenatal period and followed until the baby is 18 months of age. The investigation is designed to compare comprehensive outpatient services vs. referral to existing community programs. The intervention group receives prenatal care, group drug treatment, nutritional counseling, transportation, child care, structured recreational activities, home management instruction and "mommy and me" activities.

University of Southern California School of Social Work
Los Angeles, CA
Comprehensive Day Treatment
Hospital based outpatient treatment
This study is designed to compare the relative effectiveness of day treatment vs. traditional outpatient models and to identify for whom each treatment model works best.

University of Southern California, San Diego Medical Center
San Diego, CA
Hospital based outpatient treatment
Teen participants are randomly assigned to one of eight conditions for two treatment factors: (1) Skills training (none, social, network, life), and (2) case management (none, clinical).

The APT Foundation, Inc. / Yale University School of Medicine
New Haven, CT
Hospital based outpatient clinic
This project is designed to determine prevalence of cocaine/crack use in women seeking prenatal care; to identify the characteristics and treatment needs of eligible subjects; and to compare the effectiveness of comprehensive day treatment and clinic-based weekly treatment; and to establish a longitudinal database of the effects of in utero exposure on the developing child.

University of Miami Medical School
Miami, FL
Hospital-based outpatient clinic
This project is designed to assess a 40 hour per week intervention/prevention program for two groups of teenaged girls: One group consists of teenaged mothers who reported using drugs during pregnancy and the other group consists of teenaged mothers at-risk-for using drugs by virtue of their depression and pre-pregnancy drug use and/or drug using environment.

Operation PAR, Inc.
St. Petersburg/Tampa, FL
Non-medically-based residential Therapeutic Community (TC)
This project examined whether mothers permitted to live with their children during long-term therapeutic community residential treatment will stay in treatment longer and have better treatment outcomes than mothers in standard residential treatment, where children remain in the community with relatives or are placed in foster care. It is the only project that is completed under the NIDA program. Preliminary data from this project indicated that mothers permitted to live with their children during treatment did remain in treatment longer.

Cook County Hospital
Chicago, IL
Comprehensive outpatient program
This research project is designed to compare a comprehensive, intensive drug treatment program including coordinated prenatal, obstetric and pediatric care (one stop shopping) with treatment as usual including referral to community agencies.

National Association for Perinatal Addiction, Research and Education (NAPARE)
Chicago, IL
Hospital-based comprehensive outpatient program
This research project is designed to compare the effectiveness of residential treatment vs. outpatient treatment for pregnant women in changing the following: pattern of drug use in pregnancy, complications of labor and delivery, maternal retention in treatment, fetal growth, neonatal neurobehavior, infant growth and development, maternal postpartum relapse patterns, and maternal attitudes and adjustments.

Boston University School of Medicine
Comprehensive Day Treatment
Neighborhood multiservice facility & hospital-based outpatient clinic
This research project is designed to compare standard hospital based-outpatient care to a comprehensive neighborhood based treatment program including prenatal care, drug treatment, pediatric medical and early intervention with childcare and transportation.

Johns Hopkins University School of Medicine
Intensive day treatment and "standard" outpatient care
Hospital-based outpatient clinic
This research project is designed to compare specialized women's substance abuse treatment with traditional mixed-gender treatment for reduction of drug use and improvement of psychosocial status for drug abusing women.

National Public Services Research Institute
Landover, MD
Intensive outpatient & 28-day residential treatment
This research is designed to randomly assign mothers who have delivered cocaine-exposed babies to one of three conditions: intensive outpatient with childcare, short-term residential with children and non-intervention. The two treatment groups are provided cost-free drug treatment, case management services, child care, transportation and linkages to other community services over a 6 month period. The non-intervention group is given a referral to treatment in the community but is not provided treatment through the project. All subjects are followed for 2 years. This project also compares drug analysis of mothers' hair, babies' hair, mothers' urine and self-report.

Montefiore Medical Center
Bronx, New York
Comprehensive outpatient with family-based case management
Hospital-base outpatient clinic
This research project is designed to compare family systems model intervention with standard care for drug using mothers.
Outcome variables include:
Child: healthcare maintenance, appointments made, appointments kept, hospitalizations, illnesses, custody
Mother: healthcare maintenance, drug use assessment - past, ongoing, changes in social networks, changes in residence and household composition, utilization of legal services and assessment of legal needs, entitlement needs assessments
Family: unification of mother with children, changes in frequency of contact with children in nonmaternal foster care, caregiver-child interaction assessments, family configuration measure

St. Luke's Roosevelt Hospital Center
New York, New York
Comprehensive outpatient treatment program
Hospital-based outpatient clinic
This research is designed to assess the effectiveness of a comprehensive care model (one stop shopping) which includes a broad array of health and related social services with a specific drug treatment intervention. Women are randomly selected in one of three groups: One groups receives the total program; the second group receives comprehensive health and social services with referral out for drug treatment; the third group receives routine post partum care plus referral out to drug treatment.

SUNY Health Sciences Center at Brooklyn
New York, New York
Communication skills training program for pregnant women
Hospital-based outpatient clinic
The primary objective of this research is to assess the impact of introducing communication skills training (CST) into standard substance abuse care of pregnant substance abusers. Outcome variables include: Participation in substance abuse treatment and medical care services; use of substances; stress level and depression; self-reported coping strategies; perceived social and instrumental support resources; indicators of quality of daily functioning and social interpersonal relationships.

Cleveland State University
Cleveland, Ohio
Comprehensive outpatient program with computer-assisted case management
Hospital-based outpatient
This longitudinal research is designed to compare care for pregnant substance abusing women over a 24 month period with and without computer-assisted case management.
Outcome variables include: Mothers health, severity of drug use, babies health, and social network changes.

Thomas Jefferson University Family Center
Philadelphia, PA
Comprehensive outpatient program
Hospital-based outpatient clinic plus independent housing
This longitudinal study compares maternal and child outcomes of families over a 30 month postpartum period. Pregnant substance abusing women are randomly assigned to 3 conditions: 1. residential treatment, 2. outpatient treatment with vocational training, and 3. outpatient treatment alone.

Medical College of Virginia Hospitals
Richmond, Virginia
Comprehensive outpatient treatment
Hospital-based outpatient clinic plus independent housing

Washington State Division of Alcohol and Substance Abuse
Olympia/Seattle, Washington
Comprehensive outpatient, intensive inpatient and residential treatment
Hospital-based inpatient unit, outpatient clinic, and (non-TC) therapeutic residential facility
Pregnant substance abusing women are randomly assigned to 4 treatment conditions, long-term residential, short-term residential with outpatient follow-up, intensive outpatient and community based care.

Preliminary Findings:

<u>major barriers to successful treatment</u>
lack of adequate child care
employment barriers (employment schedules does not allow attendance)
lack of transportation
partners drug use
lack of support for treatment

<u>major treatment issues</u>
history of suicide attempts
history of rape
history of physical abuse and violence
deficient parenting skills
deficient communication skills
deficient self-discipline
presence of psychiatric disorders including paranoia, thought disorder, depression and anxiety in addition to alcohol and drug abuse
presence of personality disorders including avoidant, antisocial and self-defeating
history of abortion

<u>measurement issues</u>
ASI (Addiction Severity Index) needs adaptation to female subjects
Brazleton need adaptation to drug exposed infants

APPENDIX J:

ADMINISTRATION FOR CHILDREN AND FAMILIES

Child Welfare, Foster Care, Family Preservation

The recent rise in infant admissions to foster care suggests continued increases in foster care caseloads. Not only do younger children spend the longest time in foster care, but historically younger children often reenter the system throughout childhood. A 1988 Illinois study by Testa and George found nearly 40 percent of the youngest foster children who were reunified with parents eventually reentered substitute care (Greenbook, 1991). The family preservation model is seen as a viable option to an already overloaded child welfare system.

The essential features of the family preservation model are:

- 24 hour, 7 day a week availability for families
- small caseloads, usually not more than 2 families
- services provided in home
- intervention focuses on family needs and strengths
- short term intensive services for 4 to 6 weeks
- referral to support services and additional counseling

In the first week, workers frequently provide 15 to 20 hours of service. This intense period allows for thorough assessment of family needs and strengths. In subsequent weeks,

families receive an average of 8 to 10 hours of service weekly. During this time, workers stabilize the family crises by teaching and modeling appropriate behaviors within the home environment. They also arrange for concrete assistance in the form of rent deposits, food, or transportation.

The goals of family preservation are to build on family strengths and to empower families by teaching them how to problem-solve and how to access community support systems. Family preservation is designed to lessen dependence on the caseworker and to enable the family to access and receive community assistance if they choose. These goals represent a significant shift in the delivery of services. Table 1 compares the differences between the traditional model of child welfare service and the family preservation model of service.

FUNDING

The Social Security Act contains four primary sources of funds available to states for child welfare, foster care and adoption services. These programs are administered under the Administration for Children and Families and include title IV-B child welfare services program assistance, title IV-E foster care , title IV-E adoption assistance and title XX social services block grant. The adoption assistance program aids States with adoption of AFDC or SSI eligible children with special needs such as age, sibling groups, mental or physical handicaps, or ethnic background.

According to the National Conference of State Legislatures (1991), the cost of family preservation services is significantly lower than traditional welfare services. In Maryland, annual costs per child in the child welfare system averaged $14,400 in 1990. A juvenile justice placement in New York costs approximately $70,000 per year. A publicly-paid psychiatric stay

averages $16,000. A typical family preservation service costs between $2000 and $3000 per family annually. Moreover, data indicate that most children served by the family preservation model avoid out of home placement in the 12 months following intervention. Although the model shows promise for helping drug exposed children and their families, its effectiveness depends on the skill of the personnel who implement it and the availability of community resources. Recovery from an addiction requires at least two years of treatment and support. Family preservation provides the essential bridge to that treatment.

State legislatures are the primary funding source for family preservation and child welfare services. Estimates of the proportion of state funds that support child welfare services range from 60 to 66 percent. States finance both traditional fostercare services and alternative services, such as family preservation. Despite the original intent of P.L. 96-272 to provide financial incentives for states to develop family-based child welfare systems, expenditures for such services lag far behind states' disbursements for out-of-home care.

Although Family Preservation has been shown to be cost effective, the residential-care orientation of most child welfare agencies has been difficult to change. Traditional financing and reimbursement mechanisms present major obstacles. Federal financing under P.L.96-272 provides open-ended matching funds for out-of-home placement maintenance costs for eligible children under title IV-E but limits reimbursement for placement alternatives to a fixed dollar amount for each state under IV-B. Consequently, foster care, the most expensive child welfare service, operates as an entitlement in most states.

The cost effective argument has provided legislative sponsors with data to convince their colleagues that family preservation projects can be offset by reduced child welfare expenditures. Alabama, Colorado, Florida, Georgia, Illinois, Kentucky, Michigan, Missouri, New Jersey,

New York, Tennessee, Texas, and West Virginia have authorized the use of foster care dollars to finance family preservation programs.

Three resources are currently being used alone or in combination by states to finance family preservation programs: 1. State general revenues, 2. reallocation of current foster care or discretionary funds, 3. Federal financial participation (FFP) opportunities. The first option involves state-only dollars. The second option refers to earmarking a portion of previously budgeted allocation, such as foster care expenditures or projected increases in foster care, to develop family preservation services as an alternative. The third refers to efforts to maximize federal funding by increasing reimbursement for various child welfare activities from federal funding sources such as Title IV-E claims.

Title IV-E provides open-ended foster care maintenance payments for eligible children at each state's Medicaid matching rate. The program also provides reimbursement for administrative costs for preplacement services at 50 percent matching rate and for training costs at 75 percent matching rate. Many of these activities are required to comply with P.L.96-272.

Several Medicaid options available to the states also provide opportunities to finance family preservation services: Early and Periodic Screening, Diagnosis and Treatment (EPSDT), rehabilitation services and case management provisions. It is estimated that 30 to 50 percent of the costs of family preservation for Medicaid recipients could be recouped through this mechanism (Smith, 1991).

FEDERAL FUNDING SOURCES FOR FAMILY PRESERVATION SERVICES INCLUDE:

Title IV-B of the Social Security Act:
- Subsidizes states' child welfare service costs
- no federal eligibility requirements
- 75% federal match
- $300.6 million FY91

Title IV-E of the Social Security Act:
- Subsidizes states' foster care costs
- AFDC eligible children
- Maintenance - state Medicaid match rate 50%-80%
- Administrative-50% Training-75%
- $1.78 Million FY91

National Child Abuse and Neglect state grants:
- Prevention and treatment of abuse and neglect
- States must have reporting, investigation and confidentiality provisions according to federal guidelines
- no state match
- $16.5 million FY91

Title XX of the Social Security Act:
- Block grant to fund social services program
- No federal eligibility criteria
- No state match required
- $2.8 Billion FY91

Alcohol, Drug Abuse and Mental Health Grant:
- Funding for community mental health, drug abuse and alcohol abuse services for substance abusing individuals
- No state match required
- $1.2 billion FY91 (10% for children's services)

AFDC Emergency Assistance (EA)
- Emergency needs of low income families and children
- AFDC children under 21 and their families
- services authorized for one continuous 30 day period in any 12 months
- AFDC eligibility can be waived by the state
- federal match 50%
- $205 Million FY91

Medicaid, title XIX of the Social Security Act
- eligibility includes pregnant women, children up to age 6 at 133% of poverty level, and all AFDC eligible individuals

- federal match 30% to 80%
- $36.9 billion for FY91

PRIVATE SOURCES FOR FUNDING FOR CHILDREN, YOUTH, AND FAMILY SERVICES:

Carnegie Corporation of New York - Child Care Quality

This project assists state legislators to improve the quality of state child are service. Issue areas include: financing, licensing and regulation, affordable credentials and ongoing training programs for providers, support systems for family day care providers, administrative structures for state child care services and affordable quality programs for low-income families

Edna McConnell Clark Foundation - Child Welfare

This project assists state legislators to improve state systems that serve children and families in crisis. Out-of-home placement is the most expensive form of service and contributes to trauma for the child and instability for the family. With increasing placements and costs, states are exploring service alternative. Information is available on family preservation services, adoption, other placement alternative, interagency coordination and collaboration, financing services, and child abuse and neglect.

Ford Foundation, Charles Stewart Mott Foundations and the Foundation for State Legislatures - Community Development

This project assists state legislatures to explore methods to integrate the human services and economic development programs developed for distressed urban communities. The project focuses on the role of community development corporations to tailor housing, economic

development, and social services programs to specific community needs.

Other programs under ACF

Children of Substance Abusers

with the authorization levels at $50 million for FY93.

Home Visiting Services for at Risk Families,

provides grants for increasing the use of and information on prenatal care, especially in high risk

that are susceptible to substance abuse.

Authorization levels for FY93 at $30 million.

APPENDIX K:

ADMINISTRATION FOR CHILDREN, YOUTH AND FAMILIES

Head Start

Head Start is locally administered by community based non-profit organizations and school systems. Any local government, federally-recognized Indian tribe, or private non-profit agency which meets the requirements is eligible to apply for a grant. Grantee agencies may subcontract with other child-serving agencies to provide services to Head Start children. Most grants are awarded by the Department of Health and Human Services regional offices, except for the American Indian and Migrant programs, which are administered in Washington, D.C. Legislation requires that the federal share allocated to Head Start programs shall not exceed 80% of the operating costs. The remaining 20% must be contributed by the community or state in cash or contributed services.

The Head Start Bureau has established three priority areas to combat these problems:

- Priority Area One: Family Service Centers
- Priority Area Two: Building Head Start Grantees Capacity to Address Substance Abuse and Collaboration Between Head Start Grantees and Target Cities Programs
- Priority Area Three: Building a Head Start Program's Capacity to Address a Specific Problem Threatening Head Start Families

○ **Priority Area One**: Family Service Center Demonstrations. This program is part of a national demonstration program to test the Family Service Center approach to meeting the needs of families with problems with substance abuse, employability and literacy. Family Service Center Demonstrations grantees work on strengthening family support and improving the capacity to

address all three of these issues. The Family Service Center provides assessment and identification of community resources; joint advocacy for services responsible to the needs of Head Start families; the development of a referral networks for Head Start families who need assistance beyond what Head Start can provide; and the identification and securing of culturally sensitive health and social service expertise in the areas of substance abuse. Other components of the Family Service Centers include a case management system for each family and intensive training of employees.

○**Priority Area Two**: Five elements that help build and enhance the capacity of Head Start grantees to comprehensively address issues related to substance abuse.

1. Develop staff capacity to be aware of the problem and to assist families and children in addressing alcohol and drug issues.

2. Identify and provide early intervention and referral services for staff and families abusing alcohol or drugs.

3. Respond to the special needs of children who are from families currently abusing substances or who exhibit harmful effects of exposure to alcohol or drugs, either prenatal or postnatal.

4. Help high-risk families and staff to better understand substance abuse and how to strengthen their ability to live drug and alcohol-free lives.

5.Develop and support efforts to work collaboratively with community-based, regional or State programs and organizations to achieve community-based objectives which address substance abuse or community violence.

○ **Priority Area Two**: Section B: Collaboration Between Head Start Grantees and Target Cities Programs. The purpose of this priority area is to support the development of collaborative efforts between Head Start grantees and Target City grantees to improve the provision of treatment and support for head Start families affected by substance abuse. Eligible applicants are Head Start grantees located in the eight cities which are also the site of a Target Cities grant funded by the Center for Substance Abuse Treatment (CSAT).

Target Cities Grants were awarded to the State Drug Abuse Agencies to complete the following objectives: to improve patient retention and reduce relapse; to improve the quality and retention of staff; to provide a full range of drug treatment and related health and human services; and to improve treatment services for at least one of the city's critical populations, which includes pregnant drug abusers. First year awards were made in September 1990 for three years. Grantees and awards were as follows:

Boston, MA	$4,503,183
Baltimore, MD	$4,485,063
Los Angeles, CA	$4,087,866
Atlanta, GA	$3,961,235
San Juan, PR	$3,806,700
New York, NY	$3,677,768
Albuquerque, NM	$2,474,768
Milwaukee, WI	$1,469,399

Head Start Bureau is seeking applications from Head Start grantees located in these Target Cities to propose specific, joint initiatives and activities with the Target Cities projects, which will be mutually beneficial to the two programs. Grants available to Head Start grantees are for $100,000.

○**Priority Area Three**: Building a Head Start Program's Capacity to Address a Specific Problem Threatening Head Start Families

The purpose of this priority area is to strengthen and enhance the capacity of Head Start grantees to more effectively address a specific presenting problem which is experienced by a significant number of Head Start families in that community, and which requires extra services and support in order for these families to take full advantage of the program. A grantee should take a comprehensive approach to addressing a specific problem by utilizing case management, defining the problem, developing comprehensive solutions by using all Head Start components, and establishing linkages with existing services.

APPENDIX L:

Listing of Services for which Federal Financial Participation is Available Under Medicaid (§ 1905(a))

Minimum EPSDT Services

1. Periodic screens
2. Interperiodic screens
3. Vision, dental and hearing care
4. Diagnostic services
5. The following treatment benefits:

- Podiatrist services
- Optometrist services
- Chiropractor services
- Physician services
- Medical and remedial care recognized under state law and furnished by licensed practitioners practicing within the scope of their practice (i.e., psychologists)
- Home health services
- Private duty nursing services
- Clinic services furnished under physician direction
- Nursing facility services
- Inpatient hospital care
- Outpatient hospital care
- Personal care services
- Transportation
- Case management (defined as any services that will assist individuals gain access to needed medical, educational, social, and other services)
- Hospice care
- Preventive services
- Federally qualified health center and rural health clinic services
- Family planning
- Laboratory and x-ray services
- Emergency hospital services
- Rehabilitation services
- Intermediate care facilities
- Intermediate care facility services for the mentally retarded
- Inpatient psychiatric services
- Christian Science nurses/ sanatoria

- Physical therapy and related services
- Occupational therapy
- Speech, language, hearing
- Prescribed drugs, dentures, and prostheses
- Dental services (including medical and surgical services)
- Eyeglasses
- Nurse midwife services where the midwife is legally authorized to perform under state law
- Respiratory care
- Certified pediatric and family nurse practitioner services
- Community supported living arrangements for persons with developmental disabilities
- Other diagnostic, screening, preventive, and medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, for the maximum reduction of a physical or mental disability

PERIODICITY SCHEDULE BY AGE

The columns across the top of the Periodicity Schedule by Age represent the age brackets during which a client is periodically eligible for medical screening. The column down the left of the chart lists the procedures that must be performed during an EPSDT screen. Any time a client enters the program or has not received a procedure at the appropriate age, he/she should be brought up to date as soon as possible. Refer to the footnote instructions at the bottom of the chart.

AGE [1]	Inpt. Newborn	INFANCY						EARLY CHILDHOOD					LATE CHILDHOOD					ADOLESCENCE			
		1 mo.	2 mos.	4 mos.	6 mos.	9 mos.	12 mos.	15 mos.	18 mos.	24 mos.	3 yrs.	4 yrs.	5 yrs.	6 yrs.	8 yrs.	10 yrs.	12 yrs.	14 yrs.	16 yrs.	18 yrs.	20 yrs.
HISTORY																					
Physical & Mental Health Development	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION [2]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																					
Height/Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hct	•	•	•	•	•	•	•	•	•												
B/P												•	•	•	•	•	•	•	•	•	•
NUTRITIONAL ASSESSMENT		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DEVELOPMENTAL ASSESSMENT		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MENTAL HEALTH ASSESSMENT		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																					
Vision Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hearing Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
TUBERCULIN TEST							•	✓	✓	•	•	•	•	•	•	•	•	•	•	•	•
LABORATORY PROCEDURES [3]																					
a. Newborn Hered./Metabolic Screening [4]	•	•	✓	✓	✓																
b. Hgb or Hct					•	✓	✓	✓	✓	✓	✓	✓	✓	•	✓	✓	✓	✓	✓	✓	✓
c. Lead Screening [5]					•	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
d. Rubella Screening																	•	✓	✓	✓	✓
e. RPR Card Test																	•	✓	•	✓	✓
f. Hemoglobin Type																	•	✓	✓	✓	✓
IMMUNIZATIONS [6]			•	•	•			•					•	✓	✓			•	✓		
DENTAL REFERRAL [7]											•	•	•	•	•	•	•	•	•	•	•
HEALTH EDUCATION [8]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the required age, the schedule is to be brought up to date.
2. A complete physical exam is required at each visit, with infant totally unclothed, older children undressed and suitably draped.
3. A federally mandated screening procedure. Clients are not to be referred to a laboratory for completion of the service.
4. Metabolic screening (e.g., thyroid, PKU, Galactosemia) is to be done according to state law.
5. Mandatory for all children at risk — regardless of age.
6. A federally mandated screening procedure. Clients are not to be referred to the Health Department.
7. Dental referrals required for all clients three years of age and older.
8. Counseling/anticipatory guidance are a required integral part of each visit.

Key: • Required
✓ Check — Required unless already provided on a previous screen at the required age and documented on the claim form with date of service performed.

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APPENDIX M: HEALTH CARE FINANCING ADMINISTRATION (HCFA)

MEDICAID

State Plan and Federal Match Formula Varies Among States

Medicaid is a cooperative federal/state entitlement regulated by federal law, Title XIX of the Social Security Act of 1965, and administrated by HCFA (Health Care Financing Administration). The federal contribution to Medicaid varies from state to state according to a formula based on per capita income. It ranges from 50% for the wealthiest to **83%** for the poorest. To qualify for the federal contribution, states are required to submit a state plan which specifies the services and the eligibility of providers and individuals to be covered (Greenbook, 1992).

As an entitlement program, Medicaid is not subject to Congressional discretionary appropriations. Medicaid is designed to finance services that typically fit the medical model. Although most states cover acute inpatient care, there are very few long term substance abuse treatment options for Medicaid patient. Access to long term care is critical if treatment for addicted pregnant women is to be successful.

To improve access to extended treatment, Gates (1992) suggested that states could make reimbursement for detoxification services contingent on coordination with long term treatment placement or designate specialized case management services as part of the state plan. Other problems with access to long term care are related to insufficient reimbursement under Medicaid. Washington State solved this problem by designing a special Medicaid coverage system for pregnant women which reimburses intensive service programs at a 85% to 95% of actual cost.

Non-Hospital Residential Settings and The IMD Exclusion

According to HCFA regulation, Medicaid excludes from coverage a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care and related services. HCFA defines substance abuse as a mental disorder and a substance treatment center of less than 16 beds as an institution for mental diseases. Known as the IMD exclusion, it effectively creates a barrier to most existing substance abuse treatment services for indigent individuals between the ages of 21 and 65.

Since HCFA has ruled that children must be included in the 16 bed limit, babies who are delivered during a mothers treatment must be counted. If providers allow the mothers to keep their children with them, they limit the number of women who can be treated. If the children are placed in foster care while the mother receives treatment, the mother will lose AFDC benefits and therefore Medicaid eligibility, her means to pay for treatment.

Solutions to the IMD Exclusion

Providers have bypassed the IMD exclusion by separating room and board from treatment services. Within these programs, Medicaid funds typically cover intensive outpatient services and non-Medicaid sources such as state revenues and block grant funds pay for room and board. Missouri and Minnesota are examples of states who have used this remedy.

The Medicaid Family Care Act has been proposed to change Medicaid regulations to expand substance abuse services for women with children. Reintroduced in the Fall 1992 session, the bill proposed to alleviate the IMD problem by excluding non-hospital residential treatment for pregnant women and their children from this regulation. Thus far, this legislation

has not been passed. States may also request a Section 1115 waiver which would allow residential treatment to be covered by Medicaid. This option is currently being tested through HCFA demonstration projects, a description of which follows this discussion. Targeted case management as a optional service within a state plan can be used to coordinate a wide variety of comprehensive services for substance abusing pregnant women and does not require special approval from HCFA to do so. The state need only to amend the state Medicaid plan to include the service.

Medicaid For Substance Abuse Treatment Services

Despite the potential for Medicaid as a funding stream for substance abuse treatment, states and treatment providers often become discouraged by complex regulations and application process prescribed by federal requirements. As a consequence, many states are spending large amounts of their own revenue dollars to finance substance abuse treatment. In 1988, states spent twice as much on substance abuse treatment as did the federal government.

Resources for State Match

Gates (1992) has suggested several ways to raise state revenue to access additional Medicaid funding for addicted pregnant women:

- Transferring Alcohol and Drug Agency Funds
- Alcohol Excise Taxes
- State Tax Check-offs
- State Forfeiture Proceeds

Transferring Alcohol and Drug Agency Funds:

States can transfer general state revenues intended for alcohol and drug services to the state Medicaid agency rather than to the state division of alcohol and drug abuse. Since transferred funds to Medicaid are eligible for federal match, this process allows the states to increase the Medicaid resources for alcohol and drug treatment . Illinois is one example of a state that has used this mechanism to expand substance abuse treatment services under Medicaid.

Alcohol Excise Taxes:

Revenue created by state taxes on alcoholic beverages may also be used for Medicaid match funds. Although a higher tax often brings political opposition, the combination of concern for substance abuse treatment and the opportunity to double the revenues through Medicaid can make such a tax increase attractive.

State Tax Check-off:

If a state has an income tax, the tax form may have a check-off box that allows the taxpayer to designate a portion of their refunds or to increase their tax liability for a specific purpose. For example, extra revenue may be directed to alcohol and drug abuse treatment centers or to a fund for maternal and child health services.

State Forfeiture Proceeds:

Revenue generated by forfeiture of property confiscated during convictions of a drug related crime may also be used for match for Medicaid funds. This property includes cars, boats and houses seized by the state or local government and sold at auction. The proceeds usually go

the state attorney general, state police or local police or agency, but an amendment of state law can designate a percentage of the forfeiture for substance abuse treatment . If the amendment of state law meets resistance, some larger police offices and the attorney general's office can be lobbied to donate their state forfeiture funds for substance abuse treatment.

APPENDIX N:

DEMONSTRATION GRANTS FOR IMPROVING ACCESS TO CARE FOR PREGNANT SUBSTANCE ABUSERS (HCFA)

A total of $6 million has been awarded by Health Care Financing Administration(HCFA) to administer and monitor 5 demonstration projects. Funding for the projects is for up to 12-month development period, 3 years of service delivery, and a 6-month phase-out period. The purpose of this program is to increase the number of Medicaid-eligible pregnant substance abusers who receive coordinated perinatal care services, substance abuse treatment and other services to promote better health outcomes for themselves and their offspring. Awards were made September 1991 to the following states: Maryland, Massachusetts, New York, South Carolina and Washington. Features common to the projects include: case-finding, case management, provider training, community outreach, and other ancillary services(e.g., parenting education, nutrition counseling, transportation). In addition, Massachusetts, New York and Washington are requesting waivers to provide services in an IMD setting.

WASHINGTON

- The Yakima First Steps Mobilization Project for Pregnant Substance Abusers will take place in Yakima County, the seventh largest county in the state. This largely rural, agricultural county has the highest teen pregnancy rate in the State and ranks as one of the top 10 counties in the U.S. In 1989, it was designated by the State as a Maternal Care Access Distress Area.
- Yakima County has a relatively high population of Hispanics and Native Americans. These women would be specifically targeted for culturally relevant and bilingual outreach and treatment services.
- This project will include an expansion of Yakima's established outreach and case find programs to identify and recruit low-income substance abusing pregnant women who do not currently receive health care or drug treatment. Specialized training on chemical dependency will be provided to the case finders and others who have initial contact with the women,

including churches, jails and courts, school personnel, etc.

- This project would establish a new "mobile" Alcoholism Drug Addiction Treatment and Support Act (ADATSA) position to travel to various social service and health care agencies in the country when a pregnant woman had been identified who may be in need of treatment for substance abuse. The ADATSA worker can determine preliminary Medicaid Eligibility and, following assessment, the ADATSA worker would determine treatment options.
- The project will incorporate services provided in two institutions for mental diseases: the Reil House and the Sundown "M" Ranch. The Reil House is a long-term residential treatment program that provides treatment services for pregnant substance abusers(no children), generally 21 to 35 days in duration.
- Five medical stabilization beds will be established at the Sundown "M" Ranch for medically high risk pregnant women. Sundown "M" Ranch will establish a transfer agreement with a hospital in Yakima, hire an obstetric nurse, and negotiate for consultation with local obstetricians. Approximately 60 women will receive medical stabilization each year in this free-standing facility.
- The Division of Alcohol and Substance Abuse will contract with the Sundown "M" Ranch to provide four intensive impatient residential beds for this project. The federal match would allow expansion of services at the Reil House(e.g., a modification of its treatment curriculum to include components on anger and parenting management for the women), the addition of residential services at Sundown "M" Ranch, and an increased reimbursement rate for specialized residential services under the project.
- The project will include an enhanced case management component. This component will include the development and field testing of a model for working with pregnant substance abusers. It is estimated that 145 pregnant substance abusers would receive maternity case management under this project. Nine hundred women are expected to meet the eligibility criteria and five hundred are expected to enter treatment.

MARYLAND

- The project will target pregnant substance abusers who reside in specific areas east of Baltimore City, an area with a high prevalence of substance abuse.
- The project is a randomized clinical trial that will demonstrate the costs and effectiveness of two innovative interventions for Medicaid-eligible substance abusers, namely case management and support groups, in promoting increased enrollment of pregnant substance abusers in specialized services and ongoing prenatal care.
- The project will include case finding; specific strategies will consist of a mobile night time health van, the perinatal information line, and substance abuse screening for women and their children who are currently receiving medical services at the Johns Hopkins Hospital (JHH) pediatric and obstetrics (OB) clinics.
- Case management and support services will be provided under the auspices of the JHH Comprehensive Women's Center (CWC), in conjunction with the JHH Prenatal Care Clinic. The CWC was established in 1990 with grant funding from the Maryland Alcohol and Drug Abuse Administration. The CWC was subsequently awarded a demonstration grant from the National Institute on Drug Abuse (NIDA) to examine the effectiveness of specialized substance abuse services for women of child bearing age and to enhance the continuity of services

available at the CWC.

- The CWC is organized around three distinct components: intensive day treatment for substance abuse; specialized women's services to address the unique needs of drug-dependent women (e.g., family/relationship therapy, cognitive/behavioral interventions); and on-site gynecological, obstetrical and pediatric services.
- The first outreach strategy makes use of aggressive clinical case management to link medical and substance abuse services, as well as other related support services. This is a more intensive intervention to motivate women to participate in the OB support group and formal substance abuse treatment (CWC services). Trained case managers will closely monitor participants to ensure that coordinated services are delivered.
- The second outreach strategy is the substance abuse support group that meets weekly on-site in the JHH Prenatal Clinic. In this project, this group will be facilitated by a member of the CWC staff, who will familiarize women with the services available through the CWC and the advantages of formal treatment enrollment. It is expected that, by making substance abuse treatment staff more available to both the medical staff and the patients of the Prenatal Care Clinic, continuity of care for these women will be enhanced.
- Eligible women will be randomized into one of three groups in the project: Women in Group I will receive the standard level of care provided through the CWC plus additional outreach strategies, including case management and the substance abuse treatment support group. Those in Group II will receive the support group care only, and those in Group III(control group) will receive the standard care offered through the center.
- Two hundred participants will be randomized into Group I, two hundred to Group II, and sixty to Group III.
- The applicant does not request waivers. Participants will receive targeted case management under the provisions of Consolidated Omnibus Budget Reconciliation Act of 1985, which permitted targeted case management to Medicaid recipients. This will, however, require an amendment to the State plan.

MASSACHUSETTS

- The project focuses on enhancing current efforts in linkage and service delivery in Holyoke and two neighborhoods in Boston. It enhances efforts in five ways: It will work within the existing program of coordinating efforts to address pregnant substance abusers and provide identification and outreach to women not currently in Medicaid and in need of perinatal or substance abuse services, refer women to existing substance abuse programs, waive the statewideness and reimbursement requirements for residential services, and provide a substance abuse counselor at perinatal sites.
- The project draws heavily on perinatal initiative (Perinatal Community Initiatives Program or PCIP) for the Bureau of Parent, Child and Adolescent Health. This initiative includes community outreach and casefinding, comprehensive case management for high risk women, and linkage with other related services.
- The proposed evaluation includes two interrelated yet distinct studies, using a concurrent comparison approach. A third study, which included a comparison of communities with better linkages to drug treatment services, to cities with fewer linkages, will be assimilated into the other studies. These studies include:

-assessing the influence of using PCIP outreach and case management services, with and without drug counselors, to identify and bring drug-affected pregnant women into prenatal and drug abuse treatment services;

-monitoring the utilization of drug treatment services and comparing detoxification settings (hospital versus free-standing) and long-term treatment options (residential versus ambulatory versus no formal care);

o The project will incorporate services provided in institutions for mental diseases (IMD). IMD treatment will be compared to day treatment services.

o The emphasis on evaluation is enhanced by the way this project builds upon existing services that are being offered through the PCIP program, and Office of Substance Abuse Policy and Office of Treatment Improvement Grants. The project will enhance the existing programs by adding drug counselors to the PCIP program to facilitate earlier identification of pregnant women using illicit drugs. The effectiveness of the enhancement will be determined by comparing the enhanced sites with those that do not have the substance abuse counselor component.

NEW YORK

o The project will take place in 6 sites, 3 in New York City and 3 upstate areas, and approximately 430 eligible women will receive services. The sites were selected based on both the prevalence of maternal drug use and the systems and networks which have already been put into place to conduct outreach and case management and to gather and analyze data.

o The 3 New York City sites are of NY/NY CONNECT, an initiative on the part of New York City and State to improve access to services as well as to expand the services base in specific areas. This program, which began phase I operations in February 1991, is intended to improve birth and health outcomes for women and their infants, to reduce chemical dependency of women and their family members, and to improve family preservation.

o The lead agencies in these sites, in conjunction with several case management programs, including the New York City Health Department's Infant Mortality Initiative (IMI), and specific hospitals, identify high risk women and offer them access to medical services, child care, parenting education and, where appropriate, substance abuse treatment services facilitated by case management. The applicant requests use of demonstration funding to strengthen the existing lead agencies by adding at least one substance abuse outreach specialist per site.

o As adjuncts to the standard substance abuse treatment services, the project will arrange for the provision of the following services: perinatal care, pediatric care, developmental screening, health education (including AIDS education), family planning, parenting education, nutritional counseling, child care, vocational assessment, self esteem building and transportation.

o The project will include residential treatment programs, e.g., Odyssey House MABON (Mothers and Babies Off Narcotics), a residential program for pregnant women and women with children up to two years of age. It provides a full range of services to both mothers and children, including substance abuse treatment, health care and developmental screening for mothers and children.

o The NYC CONNECT sites will be evaluated against other control sites which will continue to operate without expanded Medicaid-eligible services. The applicant anticipates that, with the addition of Medicaid funding for services traditionally precluded from consideration,

such as outpatient counseling, day care programs, freestanding residential treatment programs and institutions for mental diseases, a substantially greater number of women will be served in the experimental areas than in the control areas which are limited in their placement options by existing Medicaid regulations.

SOUTH CAROLINA

○ This demonstration project (called"Transitions") will be conducted in South Carolina's Edisto Health District. The proposed site is a poor, both urban and rural, area where 58% of the population is African-American and 60% of women who give birth are Medicaid-eligible. Drug treatment centers report increases in crack/cocaine addiction. Approximately 330 women and their children would receive demonstration services prenatally and for 12 months postpartum.

○ The State Medicaid agency's High Risk Channeling Project (HRCP) Freedom of Choice (FOC) Wavier will be the point of entry into Transitions. The project will be used to "fill in the gaps" by providing services to accomplish a family-centered solution for clients. It will include sensitivity and support education for providers in dealing with the problems of pregnant substance abusers and will include in-depth case management for 1 year postpartum.

Services to be included in the demonstration consist of:

(a) intensive maternal outreach
(b) training of health care professionals to increase their sensitivity to the problems of pregnant substance abusers
(c) provision of transportation, child care, and other support services
(d) increased staffing at prenatal care and drug treatment facilities
(e) access to addiction counselors in hospitals for identified drug addicted women at time of delivery
(f) expanding substance abuse and HRCP (medical) case management
(g) development of an administrative oversight system to assure coordination and integration of services

This proposal includes a 5-day detoxification in a residential setting.

○ While the HRCP includes case management, the capabilities will be expanded and case management services will also be oriented to enhancing patient compliance and coordinating and linking services between providers. Uniform screening protocols will be developed to determine level of patient involvement or risk of involvement with substance abuse.

○ The project will compare the outcomes and progress in the intervention counties (Bamberg, Calhoun, and Orangeburg) with the control counties of Beaufort, Jasper, Allendale and Hampton. Both groups of counties are primarily rural, with similar distributions of population by race and socioeconomic status.

○ The control and study populations will be further matched for demographic and health indicators. Age, ethnicity, socioeconomic status, and educational level will come from the intake questionnaire. The groups will be compared for previous medical conditions and psychological status during pregnancy using their treatment medical records.

APPENDIX O:

OPERATION PAR, INC.

St. Petersburg, Florida

Programs for Addicted Women with Children

Operation PAR, Inc., offers a continuum of services for substance abusing or addicted pregnant and post-partum women. These services include:

Maternal Substance Abuse Intervention Team (I-TEAM)

The I-TEAM program was funded in February 1990 through a grant provided by the federal Office of Substance Abuse Prevention (now CSAP), Pregnant and Postpartum Women and their Infants (PPWI) program. The I-TEAM, a multi-agency team of substance abuse specialists and health care professionals, provides substance abuse assessment, treatment referral, service coordination, crises intervention, case management, and tracking services. An important component is the I-Team Steering Committee which is responsible for inter-agency service coordination by addressing service delivery gaps and barriers to accessing substance abuse treatment.

SOURCE OF FUNDING	AMOUNT	PERCENT OF TOTAL
Federal, Center for Substance Abuse(CSAP) 4 years	$340,774	100%

Children Of Substance Abusers (COSA)

In 1987, the federal Office for Substance Abuse Prevention (now CSAP) awarded a major grant to PAR to develop specialized services for infants and children effected by parental

substance abuse. The grant also addressed the needs of the mothers of the children and substance abusing pregnant women. The project known as the Child Development and Family Guidance Center, has been located in South St. Petersburg since June 1988. Therapeutic intervention services are provided at a developmental child care center which has the capacity to serve 31 children, two months to five years of age. Developmental day care and transportation services are provided to 14 additional children within family day care homes. COSA also has the capacity to serve 60 maternal substance abuser through the provision of intervention or outpatient services. Individual counseling, support groups, therapeutic groups, urinalysis testing and parenting skills training are also available to program participants. Transportation to and from the program is considered critical to its success.

SOURCE OF FUNDING	AMOUNT	PERCENT OF TOTAL
Federal, CSAP, 5 years	$203,484	42%
State, HRS	$93,881	19%
Title XX	$26,000	5%
Local, Juvenile Welfare Board	$117,582	24%
Local, Municipal Income	$2,000	1%
Local, United Way	$18,888	4%
Medicaid	$14,400	3%
Other	$10,000	2%

Detox Center

This 10 bed program provides medical detoxification and stabilization for addicted clients on a 24 hour a day basis for up to 10 days of treatment. Services for pregnant women are coordinated with her primary care physician.

SOURCE OF FUNDING	AMOUNT	PERCENT OF TOTAL
Client Fees	$18,306	3%
State/Federal, HRS	$488,447	93%
State, Florida Department of Corrections	$20,020	4%

The Therapeutic Community (TC)

The therapeutic community (TC) modality, long-term residential treatment programs with expected stays of 9 months to 2 years, provides the basic philosophy and structure for most of Operation PAR's programs. Treatment interventions consist of resocialization, milieu therapy, and behavior modification within a gradual process of occupational training and responsibility leading to community reentry. TC's are designed for individuals with major impairments and social deficits; many have histories of criminal behavior.

The TC program within Operation PAR provides long term (18-24 months) residential treatment services to more that 120 adults through a variety of counseling services, medical care, vocational and educational services, and recreational activities. The program also has special living accommodations for 14 mothers with children. Operation PAR TC has 120 treatment slots with 80 for men, 60 for women, and 25 for children. Over 80% of these clients are involved with the criminal justice system. Eighty percent of the clients have children most of whom participate in treatment through the Children of Substance Abuser (COSA) program on an outpatient basis. Transportation is provided for children of T.C. clients who are living in foster care or with a relative. Twenty five children live on campus with their mothers in the PAR Village portion of the program. Ten beds are reserved for Florida Department of Corrections inmates with substance abuse problems who complete their sentences within the treatment program. Residential and outpatient services are also provided to U.S. Probation and Parole

offenders under contract from the U.S. Courts. At any given time, there is a 4 month waiting list for a female treatment bed. However, pregnant addicted women are given priority through federal/state block grant money.

SOURCE OF FUNDING	AMOUNT	PERCENT OF TOTAL
State/Federal HRS	$1,288,302	59%
Food Stamps	$91,575	4%
Florida Department of Corrections	$229,560	11%
National School Breakfast & Lunch	$1,200	0%
Federal, U.S. Parole	$155,000	7%
County Revenue Sharing	$5,924	1%
Local, Untied Way	$68,924	3%
Client Fees	$108,280	5%
Medicaid	$48,000	2%
In-Kind Donations	$71,688	3%
Other (fund raisers/donations)	$116,100	5%
State Medicaid (4 hours of counseling, $34 per day)		
SSI for room and board from those clients who qualify		
SHARE, voluntary community program that allows $13 worth of food stamps to be traded for $35 worth of food (clients provide the food stamps)		
Department of Corrections $31 per eligible person/day		

PAR Village/ Children's Developmental Center

PAR Village is a special Operation PAR program which allows 14 addicted women to live with their children in cottages on the Operation PAR campus. The program is built on a

therapeutic community (TC) model and includes individual treatment plans, parenting classes, vocational training, and women's issues groups. Therapeutic groups emphasize that client relationships with children reflect relationships with their own parents. School age children attend school in the community, and in the evening attend therapeutic groups that are aimed at increasing self-esteem and management of emotion.

All children are screened for developmental problems by a pediatrician and psychologist. Preschool children are enrolled in a professionally staffed, developmental therapeutic day care center. PAR, in collaboration with the Department of Psychiatry and Behavioral Medicine, University of South Florida, was funded as part of the NIDA Perinatal 20 program to compare treatment outcomes for women without their children in standard TC treatment and women with children in PAR VILLAGE.

The T.C. Development Center meets the needs of prenatally and/or environmentally drug exposed infants and children. Children of any parent who is a resident of the T.C. is eligible for this program. The goal is to interrupt multigenerational chemical dependency and to decrease the developmental lags. Individual treatment plans and learning experiences foster development of cognitive, affective, motor, language, sensory and social skills. Mothers spend regular supervised time in positive interaction with their infants and children.

SOURCE OF FUNDING	AMOUNT	PERCENT OF TOTAL
NIDA (Perinatal 20 Research Demonstration Grant to Operation PAR and Univ. of South Florida Department of Psychiatry)	$142,872	11%
Federal CSAT	$787,494	61%

National School Breakfast and Lunch	$10,000	1%
State/Federal HRS	$150,000	12%
Food Stamps	$28,425	2%
Title XX	$18,500	1%
Client Fees	$26,720	2%
Medicaid	$111,000	9%
Rent	$13,250	1%
Pinellas County HUD donated 14 condemned houses that were relocated to the Operation PAR campus, and renovation was provided by the money from NIDA and OTI.		

The Comprehensive Child Abandonment Intervention Project

The FACT (families and children together) TEAM program is designed to intervene with families who have had a child placed in foster care or who are at risk for having a child removed because of a mother's substance abuse. Services include outreach, case management, pretreatment intervention, treatment groups and child care services. The FACT TEAM works to assist the mothers to regain custody of their children. The program was started in 1990 with a grant from the federal Abandoned Infants Assistance Act.

SOURCE OF FUNDING	AMOUNT	PERCENT OF TOTAL
Federal, CSAP	$568,567	84%
State/Federal, HRS	$73,353	11%
Local, United Way	$29,380	4%
Medicaid	$6,000	1%

In addition to the programs above, Operation PAR is also in the process of developing a day treatment program and transitional housing for pregnant women. The counseling portion of day treatment is funded by Medicaid. Limited transitional housing has been purchased with the help of HUD and HRS, State of Florida. Clients also pay rent.

APPENDIX P:

The CSTAR PROGRAM

Comprehensive Substance Treatment and Rehabilitation Program

State of Missouri

Programs for Women and Children

CSTAR's emphasis on women and children includes the development of nine specialized programs across the state with a capacity to serve approximately 2,000 women and 6,000-7,000 children annually. Residential support includes 24 hour staff coverage for both mothers and children. Average length of stay in the residential treatment is 60 days, with longer stays permissible pending approval from the state's Division of Alcohol and Drug Abuse (ADA). Each program is required to provide minimum services of CSTAR in addition, to residential support, child care and rent subsidy for all mothers and children. Pregnant adolescents are provided with linkages to the public school system and in-home family assessment provided by a qualified family therapist. Family education, parenting skills, discipline training and crises resolution skills are also provided within a family preservation model.

The CSTAR program finances housing with a variety of creative options for women and children through substance abuse block grant funds. ADA will purchase room and board with overnight nursing supervision in 16 bed homes for women and children and 8 bed adolescent group homes located in the community. ADA also provides rent subsidy for up to one year. In some communities, a bed and breakfast facility approved by ADA may provide room and board for CSTAR clients.

The following principles guide the provision of CSTAR services:

1. Each program provides a minimum of two years long term care with an individualized treatment plan based on the client's needs assessment. Services are offered in a least restrictive way in a community setting.

2. When possible, programs allow women and their families to receive treatment in the community where they live.

3. All children are included in residential treatment with no limit on the number of children up to age 13.

4. Extensive family involvement in the treatment process is critical to the clients success.

5. All services are designed to meet Medicaid requirements.

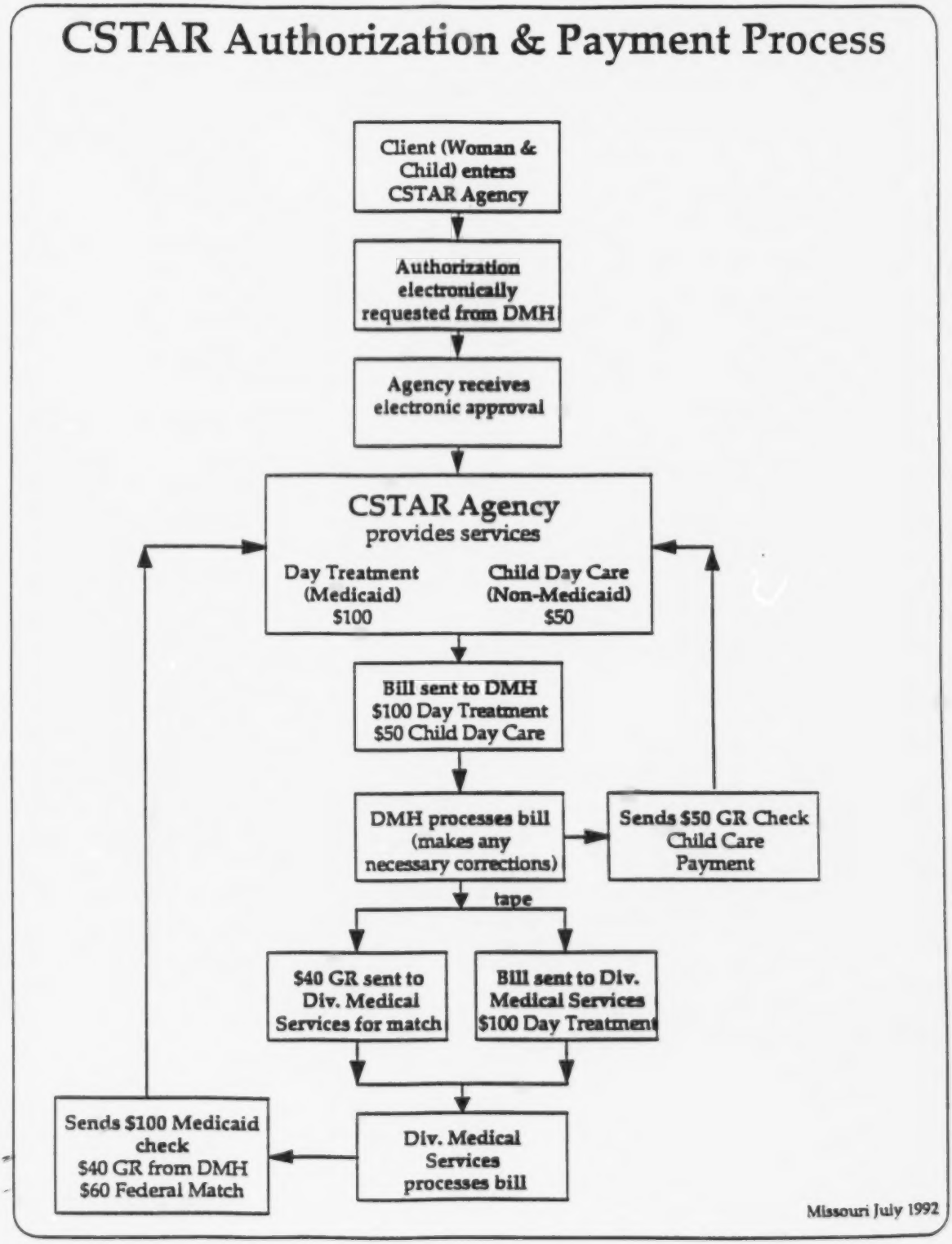
6. Each program is responsive to the individual and recognizes the need for supervised, structured, drug-free living arrangements.

CSTAR providers are required to provide the following core services:

- intake screening
- comprehensive assessment and treatment planning
- day treatment (7 days a week, 10 hours a day)
  - transportation
  - weekly drug testing
  - structured leisure activities
  - weekly family/significant other meetings
  - job preparedness and educational preparedness
  - peer support
  - development of self help skills
  - training in daily living
  - one hot meal and snacks
- individual and group counseling
- individual and group codependency counseling
- family therapy
- community support services (including advocacy and coordination with other services)
- group education
- case management (case load = 10 - 15)
- resources for exploring safe and appropriate housing
- transportation for clients to access services
- provide or arrange for child care
- 24 hour crisis intervention 7 days a week.
- provide drug-free environment with therapeutic activities that present alternatives to substance abuse and enforce rules against substance use by participants
- intervene when clients miss appointments

- individualize program to fit the unique needs of each individual.
- include family members in a treatment process that incorporates codependency counseling and referral to self-help groups in the community.

CSTAR is innovative not only in the comprehensive services it provides for substance abusing women and their children, but also in its creative use of federal funding sources. According to Leslie Jordon, Director of Treatment Services, ADA, the restructuring of services and the extra money from Medicaid makes it possible to deliver comprehensive substance abuse treatment to pregnant women and their children, but the nature of Medicaid money makes the program vulnerable to budget cuts and spending caps at the federal level. The benefits, however, far out weigh the disadvantages. CSTAR is an elegant example of how Medicaid and Federal block grant money can be blended to finance comprehensive care for pregnant women with substance abuse problems.


CSTAR Authorization & Payment Process
Client (Woman & Child) enters CSTAR Agency
Authorization electronically requested from DMH
Agency receives electronic approval
CSTAR Agency
provides services
Day Treatment (Medicaid) $100
Child Day Care (Non-Medicaid) $50
Bill sent to DMH $100 Day Treatment $50 Child Day Care
DMH processes bill (makes any necessary corrections)
Sends $50 GR Check Child Care Payment
tape
$40 GR sent to Div. Medical Services for match
Bill sent to Div. Medical Services $100 Day Treatment
Div. Medical Services processes bill
Sends $100 Medicaid check $40 GR from DMH $60 Federal Match
Missouri July 1992

WPOSMEDF.XLS 8/6/92

CSTAR SERVICES & FUNDING BY PROVIDER

Fiscal Year 1992 (July 1, 1991 - June 30, 1992)

Reimbursement by Services

Number of Providers for Program Type = 8

BluCambridge

Program Type: Women & Children - POS & Medicaid

Services	Funding Source	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Prior Months Adjustment	YTD Reimbursed	YTD Service Distribution	YTD Serv. Dist. for Program Type High	Low	Average
Intake Screening	Total	$1,383	$1,642	$864	$1,815	$1,642	$1,642	$2,334	$1,728	$1,642	$517			$11	$15,220	2%	6%	1%	3%
	Medicaid	$259	$518	$432	$605	$518	$432	$605	$864	$518	$345			$6	$5,102				
	POS	$1,124	$1,124	$432	$1,210	$1,124	$1,210	$1,729	$864	$1,124	$172			$5	$10,118				
Comp Assessment	Total	$3,462	$3,462	$4,644	$3,678	$1,514	$3,679	$4,543	$2,598	$3,462	$1,947			$8	$32,866	4%	13%	2%	8%
	Medicaid	$865	$649	$1,298	$1,514	$216	$1,082	$1,514	$865	$865	$1,082			$2	$8,950				
	POS	$2,597	$2,813	$3,246	$2,164	$1,298	$2,597	$3,029	$1,731	$2,597	$865			$3	$22,940				
Day Treatment	Total	$26,258	$31,103	$29,567	$33,116	$24,338	$26,671	$29,479	$26,307	$23,742	$25,012			$8	$275,686	33%	38%	22%	30%
	Medicaid	$7,041	$6,704	$11,681	$10,724	$8,265	$5,849	$12,264	$12,579	$10,860	$13,568			$5	$104,680				
	POS	$19,216	$24,399	$17,878	$17,392	$16,063	$20,822	$17,184	$13,728	$12,882	$11,344			$3	$170,880				
Comm Support	Total	$13,626	$17,279	$17,464	$20,725	$13,147	$13,441	$18,003	$14,941	$13,000	$11,810			$8	$153,144	18%	30%	8%	18%
	Medicaid	$4,539	$6,246	$6,208	$11,141	$4,962	$4,865	$6,882	$8,243	$6,686	$6,686			$4	$66,500				
	POS	$7,087	$11,033	$11,256	$9,584	$8,185	$8,576	$11,121	$6,698	$6,304	$4,924			$4	$84,641				
Ind Counseling	Total	$6,685	$6,685	$6,836	$8,918	$7,843	$6,732	$7,842	$6,290	$6,368	$7,132			$2	$71,088	9%	13%	2%	7%
	Medicaid	$2,182	$1,850	$1,809	$2,538	$2,303	$1,997	$2,984	$2,420	$2,385	$3,337			$2	$23,887				
	POS	$4,523	$4,735	$5,029	$6,380	$5,240	$4,735	$4,958	$3,830	$3,983	$3,795			$3	$47,211				
Grp Counseling	Total	$2,536	$2,002	$2,145	$2,376	$1,828	$1,433	$1,454	$1,488	$1,883	$2,498			$8	$19,652	2%	7%	1%	2%
	Medicaid	$1,378	$1,025	$707	$834	$804	$384	$820	$728	$858	$1,126			$4	$8,268				
	POS	$1,158	$977	$1,438	$1,542	$1,224	$1,049	$634	$760	$1,025	$1,372			$3	$11,384				
Grp Education	Total	$2,069	$1,649	$1,398	$1,264	$1,471	$1,194	$1,834	$1,558	$2,148	$2,343			$8	$17,038	2%	7%	0%	2%
	Medicaid	$1,263	$976	$230	$309	$427	$311	$709	$727	$822	$775			$3	$6,563				
	POS	$806	$673	$1,169	$955	$1,044	$883	$1,125	$831	$1,324	$1,568			$4	$10,472				
Ofl Family Ther	Total	$1,703	$2,341	$1,337	$1,870	$2,068	$1,155	$1,809	$2,022	$1,489	$1,550			$10	$17,354	2%	4%	0%	2%
	Medicaid	$317	$912	$429	$927	$806	$547	$912	$1,568	$1,078	$1,218			$6	$8,913				
	POS	$1,186	$1,429	$912	$943	$1,262	$608	$897	$456	$410	$334			$4	$8,441				
Home Family Ther	Total	$231	$451	$125	$652	$251	$125		$351	$452	$251			$6	$2,913	0%	3%		1%
	Medicaid	$231	$326	$125	$125				$351	$452	$251			$3	$1,884				
	POS		$125		$527	$251	$125							$1	$1,029				
Ind Codependency	Total	$2,119	$1,570	$951	$936	$1,253	$1,052	$1,499	$2,292	$1,638	$2,220			$8	$15,558	2%	3%		1%
	Medicaid	$1,325	$1,260	$519	$547	$706	$807	$1,211	$2,105	$1,514	$1,832			$4	$11,888				
	POS	$794	$309	$432	$389	$547	$245	$288	$187	$144	$298			$4	$3,960				
Grp Codependency	Total	$1,154	$781	$587	$524	$506	$800	$1,232	$1,467	$1,674	$1,028			$8	$9,705	1%	6%		1%
	Medicaid	$818	$486	$388	$524	$506	$636	$1,232	$1,452	$1,674	$1,028			$4	$8,758				
	POS	$286	$296	$198			$164		$15					$2	$951				
Day Care (Children)	POS	$3,950	$4,258	$4,323	$4,273	$3,272	$2,714	$3,588	$4,392	$3,830	$2,984			$4	$37,568	4%	15%	2%	8%
Supp. Housing	POS	$2,567	$3,368	$3,709	$5,085	$2,518	$2,477	$1,418	$870	$1,324	$1,114			$3	$25,779	3%	3%		1%
Women/Chdrn Res.	POS	$18,980	$17,467	$18,313	$14,800	$13,491	$12,696	$14,677	$14,648	$14,802	$13,338			$3	$149,813	18%	26%		6%
Preg Wmn Chdrn Res	POS																31%		10%
All Services	Total	$85,711	$94,058	$90,155	$100,032	$74,842	$75,811	$90,011	$81,008	$77,772	$73,524			$99	$843,023	100%			
	Medicaid	$22,448	$21,069	$23,830	$34,788	$19,363	$18,910	$29,063	$31,900	$27,723	$31,448			$48	$258,488	31%	55%	14%	34%
	POS	$63,263	$72,989	$66,325	$65,244	$55,479	$56,901	$61,048	$49,108	$50,049	$42,076			$31	$584,535	69%	86%	43%	66%
Implementation	POS																		
Meta	POS																		
Total Reimbursement	Total Med/POS	$85,711	$94,058	$90,155	$100,032	$74,842	$75,811	$90,011	$81,008	$77,772	$73,524			$99	$843,023				

APPENDIX Q:

GLOSSARY OF TERMS	
IHS	Department of Health and Human Services
ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
SAMHSA	Substance Abuse and Mental Health Services Administration
PHS	Public Health Service
OSAP/CSAP	Office of Substance Abuse Prevention; now Center for Substance Abuse Prevention
OTI/CSAT	Office of Treatment Improvement; now Center for Substance Abuse Treatment
CMHS	Center for Mental Health Services
NIH	National Institutes of Health
NIDA	National Institute on Drug Abuse
CDC	Centers for Disease Control
AHCPR	Agency for Health Care Policy and Research
FDA	Food and Drug Administration
ACF	Administration for Children and Families
SSA	Social Security Administration
HCFA	Health Care Financing Administration
BHCDA/BPHC	Bureau of Health Care Delivery and Assistance; now Bureau of Primary Health Care
OASH	Office of the Assistant Secretary for Health
NIAAA	National Institute on Alcoholism and Alcohol Abuse
IHS	Indian Health Service
NIMH	National Institute of Mental Health
MCHB	Bureau of Maternal and Child Health
ASPE	Assistant Secretary for Planning and Evaluation
OIG	Office of Inspector General
ONDCP	Office of National Drug Control Policy

HUD	Department of Housing and Urban Development
ED	Department of Education
GSA	General Services Administration
DOJ	Department of Justice
OJP	Office of Justice Programs
BJA	Bureau of Justice Assistance
NIJ	National Institute of Justice
OJJDP	Office of Juvenile Justice and Delinquency Programs
OVC	Office of Victims of Crimes
BJS	Bureau of Justice Statistics
SJI	State Justice Institute
GAO	General Accounting Office
PATSA	Block Grant for Prevention and Treatment of Substance Abuse
ADMS	Alcohol, Drug Abuse and Mental Health Services Block Grant
SSI	Supplemental Security Income
PPWI	Pregnant and Postpartum Women and their Infants Demonstration Program
NIDA 20	NIDA Perinatal 20 Research Demonstration Program
CSTAR	Comprehensive Substance Treatment and Rehabilitation Program
OPERATION PAR	Operation PAR, Inc. (Parental Awareness and Responsibility)
COSA	Children of Substance Abusers
TC	Therapeutic Community
FAS	Fetal Alcohol Syndrome
FAE	Fetal Alcohol Effect
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
AFDC	Aid to Families with Dependent Children
PREMIS	Perinatal Research and Education Management Information System
IMD	Institution for Mental Disease

ADA	Alcohol and Drug Abuse
APPWC	Addicted Pregnant and Postpartum Women with Children

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